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of the Michigan State Medical Society

Volume 47 | December, 1948 | Number 12

Heart Month—February, 1949

(See page 1384)

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Table of Contents

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(Continued on Page 1312)

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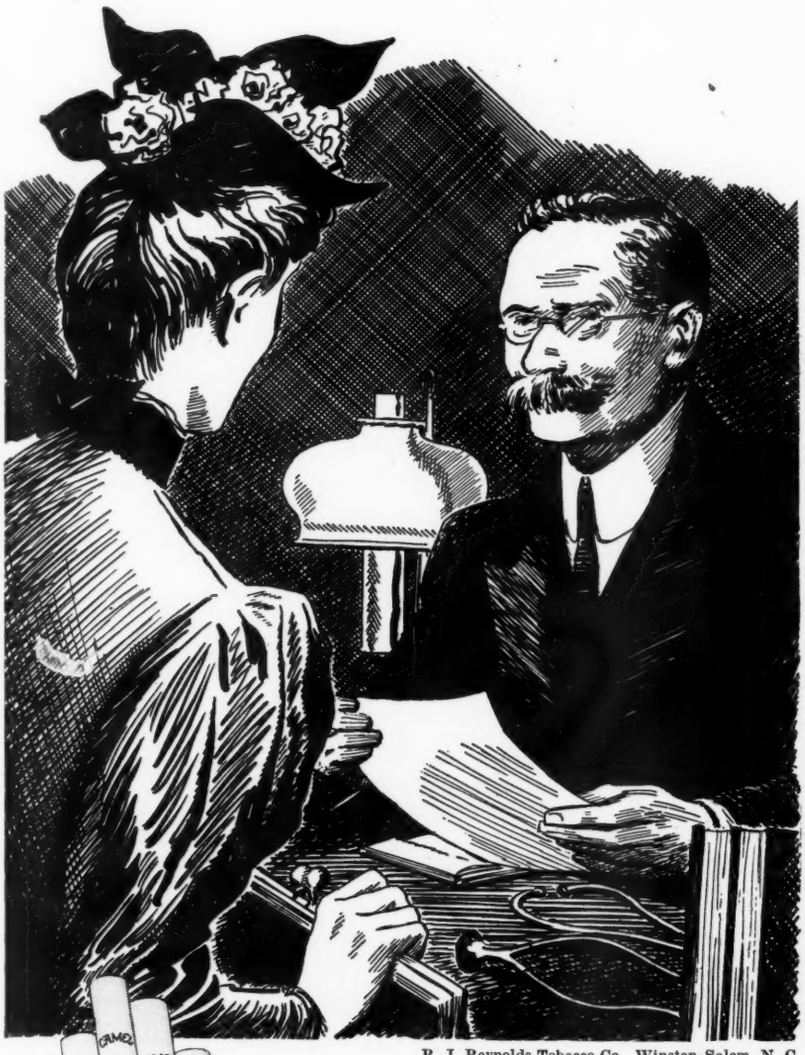

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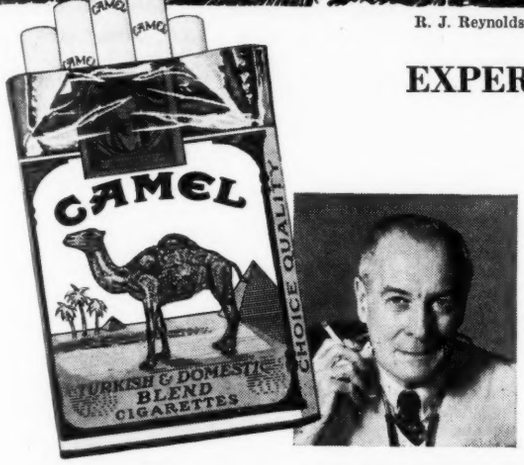

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E. I. Carr, *Vice Chairman* (1949).....300 W. Ottawa, Lansing
A. B. Aldrich (1949).....325 Harris Ave., Houghton
B. R. Corbus (1950).....Metz Building, Grand Rapids
G. J. Curry (1951).....401 Genesee Bank Bldg., Flint
A. C. Furstenberg (1951).....1313 E. Ann St., Ann Arbor
L. J. Gariepy (1949).....16401 Grand River, Detroit
John Heidenreich (1949).....Daggett
P. A. Riley (1951).....500 S. Jackson, Jackson
J. M. Robb (1950).....641 David Whitney Bldg., Detroit
J. M. Sheldon (1949).....1313 E. Ann St., Ann Arbor
W. Joe Smith (1950).....(Replacing W. B. Fillinger, resigned), Cadillac
E. D. Spalding (1950).....10 Peterboro, Detroit
F. A. Weiser (1951).....1533 David Whitney Bldg., Detroit
G. H. Scott, Ph.D., *Acting Dean*.....Dept. of Anatomy, Wayne Univ., College of Medicine, Detroit

Industrial Health Committee

H. H. Gay, *Chairman*.....Dow Chemical Co., Midland
A. L. Brooks.....Med. Dir., Fisher Body Division, Flint
W. P. Chester.....5057 Woodward, Detroit
Henry Cook.....326 Genesee Bank Bldg., Flint
W. A. Dawson.....25951 Avondale Road, Inkster
Raymond Hussey.....1547 Penobscot Bldg., Detroit
Clifford H. Keene.....2120 Wallingford Rd., Ann Arbor
V. S. Laurin.....804 Hackley Union Bank Bldg., Muskegon
K. E. Markuson.....Mich. Dept. of Health, Lansing
N. W. Scholle.....Anderson Bldg., Muskegon Heights
C. D. Selby.....15-262 General Motors Bldg., Detroit
H. T. Sethney.....Electric Square Bldg., Menominee
M. W. Shellman.....Metz Bldg., Grand Rapids
E. C. Sites.....Mich. National Bank Bldg., Port Huron
J. L. Zemans.....1761 Broadstone, Grosse Pointe Woods
A. H. Whittaker.....1427 E. Jefferson, Detroit

You and Your Business

HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 20, 1948

• Monthly financial reports and bills payable were presented, studied and approved.

• Attendance report on MSMS Annual Sessions indicated an increase of 765 per cent in thirteen sessions, from 1935 to 1948.

• Matters referred to The Council by the 1948 MSMS House of Delegates:

(a) Resolution re consultation of doctors of medicine with practitioners of other healing schools was referred to a special committee composed of J. S. DeTar, M.D., Chairman, W. E. Barstow, M.D., and C. E. Umphrey, M.D.

(b) Creation of national agency for voluntary health service plans. Action was deferred pending probable draft of a plan developed at French Lick convention of Blue Cross-Blue Shield, which plan is to be placed on the agenda of the November Executive Committee meeting.

(c) Remove block in both Basic Science and State Board of Registration in Medicine. This was referred to the Committee of Six, representative of the Michigan State Medical Society, the State Board of Examiners in Basic Sciences and the Michigan State Board of Registration in Medicine.

(d) Increase number of medical graduates in the State. This matter was thoroughly discussed and referred to a committee composed of E. F. Sladek, M.D., Chairman, J. S. DeTar, M.D., L. Fernald Foster, M.D.

• National Foundation for Infantile Paralysis—request for appointment of a Medical Advisory Committee was approved. President Sladek selected the following for the Committee: Mark F. Osterlin, M.D., Traverse City, Chairman, O. O. Beck, M.D., Birmingham, Frank Curtis, M.D., Detroit, Neil R. Moore, M.D., Bay City, and Homer H. Stryker, M.D., Kalamazoo.

• Committee reports were received from Program Committee on 1949 Michigan Postgraduate Clinical Institute; from Michigan Health Council; and from Committee on Basic Science Law Administration.

• The Public Relations Counsel's progress report included up-to-date information on the "Tell Me, Doctor" radio program; on "Lucky Junior," the

(Continued on Page 1316)

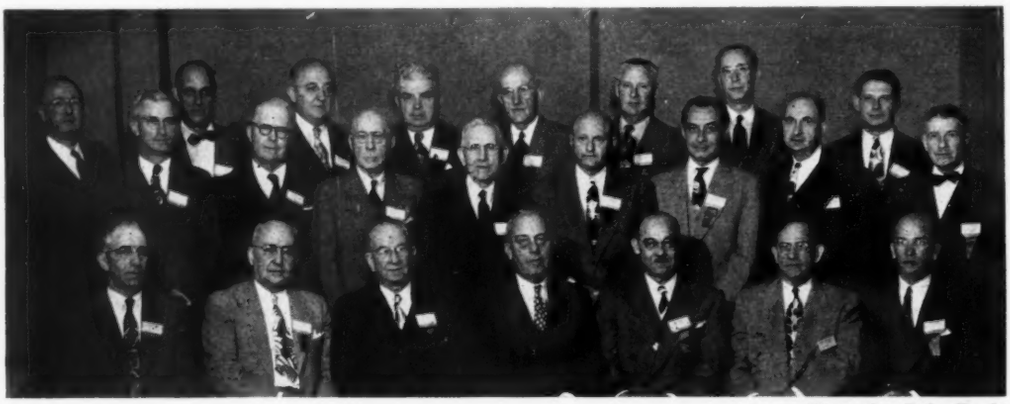


Photo by Dale Rooks

THE NEW COUNCIL—MICHIGAN STATE MEDICAL SOCIETY

Front Row, L. to R. P. L. Ledwidge, M.D., Detroit, Immediate Past President; L. Fernald Foster, M.D., Bay City, Secretary; W. E. Barstow, M.D., St. Louis, President-Elect; O. O. Beck, M.D., Birmingham, Chairman of The Council; E. F. Sladek, M.D., Traverse City, President; A. S. Brunk, M.D., Detroit, Treasurer; and J. S. DeTar, M.D., Milan, Speaker of the House.

Second Row, L. to R. W. S. Jones, M.D., Menominee; F. H. Drummond, M.D., Kawkawlin, Chairman Publication Committee; A. H. Miller, M.D., Gladstone; T. E. DeGurse, M.D., Marine City; R. C. Pochert, M.D., Owosso; William Bromme, M.D., Detroit; W. B. Harm, M.D., Detroit; and J. D. Miller, M.D., Grand Rapids, Chairman County Societies Committee.

Third Row, L. to R. E. A. Osius, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo, Vice Chairman of The Council; C. E. Umphrey, M.D., Chairman of Finance Committee; P. A. Riley, M.D., Jackson; D. W. Myers, M.D., Ann Arbor; L. C. Harvie, M.D., Saginaw; E. A. Oakes, M.D., Manistee, and C. A. Paukstis, M.D., Ludington.

HIGHLIGHTS OF THE COUNCIL MEETING

(Continued from Page 1314)

MSMS motion picture; on Medical Associates; on recent news releases; on sex education transcriptions (in co-operation with Wayne University); and on proposed 1949 Michigan Rural Health Conference.

• The Standing Committees of The Council, as appointed by Chairman O. O. Beck, were approved by the Executive Committee of The Council.

• President Sladek read the personnel of his 1948-49 committees and displayed a map showing the geographical distribution and councilor district spread of his Committee appointments for the year; appointments were approved by the Executive Committee of The Council.

• The monthly reports of the President, the President-Elect, the Editor and the Secretary were approved.

• President Sladek was selected as MSMS representative on the Medical Committee of the Michigan Chapter, American Multiple Sclerosis Society.

• J. F. Harrold, M.D., E. J. Robson, M.D., and J. F. Sander, M.D., all of Lansing, were appointed as MSMS representatives to the Governor's Conference on Youth to be held in Lansing November 12-13.

• Michigan Heart Association Organization Committee. The personnel of this Committee, as appointed by President Sladek, was approved by the Executive Committee of The Council. Additional appointments will be made to the Organization Committee at later dates.

• J. S. DeTar, M.D., Milan, was selected as Michigan's Foremost Family Physician for 1948 and his name was authorized to be submitted to the American Medical Association for its General Practice Gold Medal Award.

• The Executive Committee of The Council approved the formation of a statewide organization of Medical Assistants, provided that MSMS is requested to and does appoint an Advisory Committee to the Michigan Medical Assistants Society.

• United States Children's Bureau Advisory Committee. Inasmuch as no *practicing* doctors of medicine from Michigan have been placed on this Advisory Committee on Federal-State programs for Maternal and Child Health and Crippled Childrens Services, a committee purported to represent the "purveyors of services" to these groups, the Executive Committee of The Council instructed that a letter be dispatched to the FSA requesting that Michigan *practicing* physicians, Doctors of Medicine, be placed on this Advisory Committee.

• The present-day policy on examination of inductees was discussed and information on this subject was authorized to be sent to the Menominee County Medical Society.

• A "Cancer Control Day," to be sponsored by the MSMS Cancer Control Committee et al and to be held in Grand Rapids on Saturday, September 24, 1949, the day following the MSMS Annual Session, was approved by the Executive Committee of The Council.

• Thanks to Dr. and Mrs. Frank Van Schoick, Jackson, for their hospitality in opening their summer home to the members of the Executive Committee of The Council on this occasion were placed upon the minutes.

EXTRACTS FROM THE 1948 MSMS HOUSE OF DELEGATES PROCEEDINGS

1. From the Reference Committee's report on the Annual Reports of The Council:

"The Reference Committee approves the statement on 'Information to the Public.' The Committee believes that the money spent for public relations is wasted unless each and every doctor does his share toward good public relations in his daily contacts with the public."

2. From the Reference Committee's Report on Officers Reports:

"The Committee unanimously commends the Speaker's statements on impractices and on the Michigan Health Council. The Committee urges that all Michigan State Medical Society Delegates co-operate with the MSMS Public Relations Committee and The Council in implementing their recommendations on impractices and on the Health Councils."

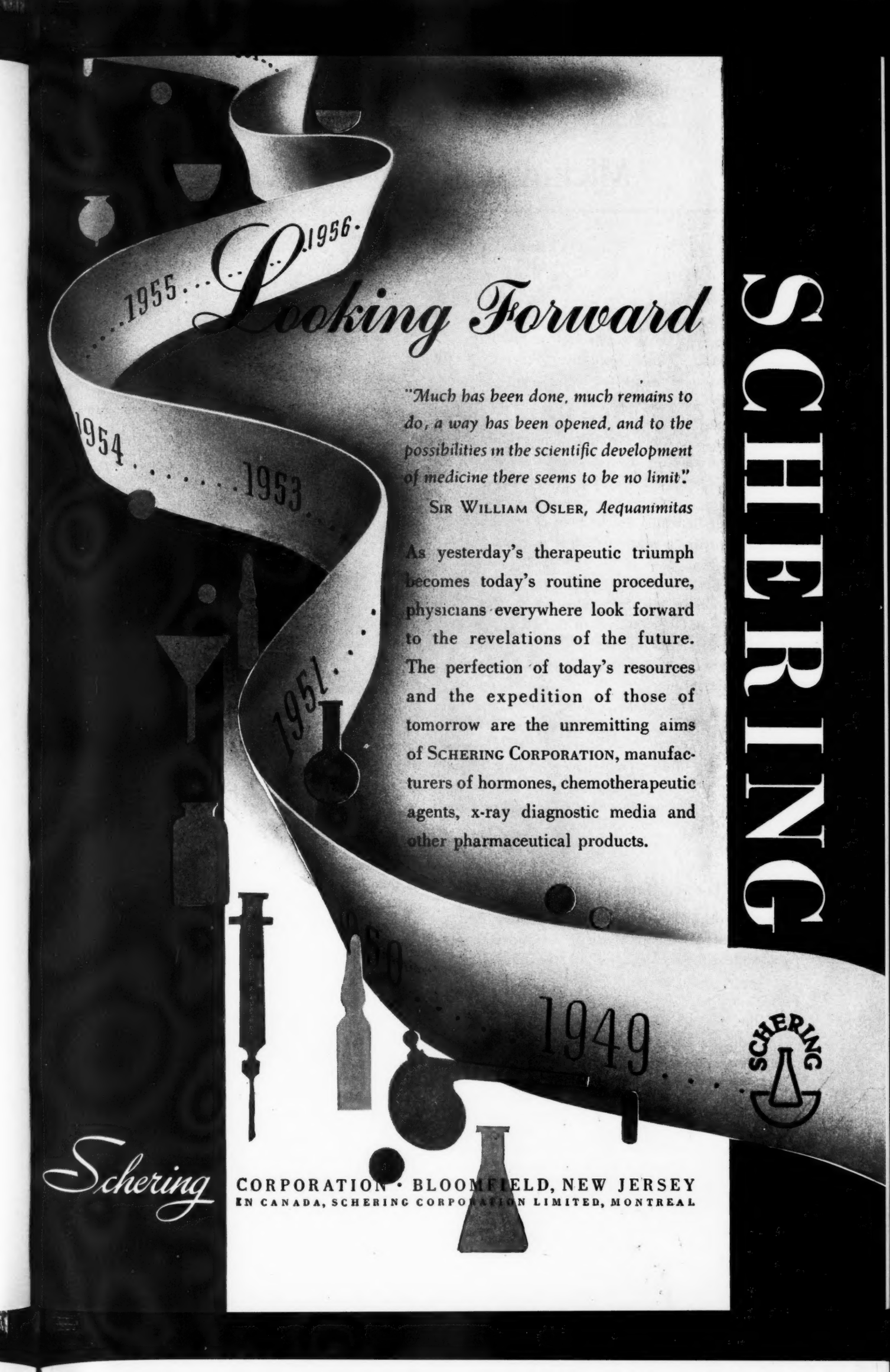
3. Ophthalmology—Substitute motion adopted by 1948 House of Delegates:

"WHEREAS, We propose to continue to conduct the practice of medicine according to the experience and judgment of a responsible medical profession, working from the scientific, sociological, and economic angles according to plans based on experience to increase the distribution of good care,

"WHEREAS, The Michigan State Medical Society is in the habit of looking at its problems squarely, fearlessly, honestly, and by analysis, and

"WHEREAS, After analysis, to approach new methods as scientific men should, by planning and experimentation, knowing that the complicated subject of economics in

(Continued on Page 1434)



"Much has been done, much remains to do, a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

SIR WILLIAM OSLER, *Aequanimitas*

As yesterday's therapeutic triumph becomes today's routine procedure, physicians everywhere look forward to the revelations of the future. The perfection of today's resources and the expedition of those of tomorrow are the unremitting aims of SCHERING CORPORATION, manufacturers of hormones, chemotherapeutic agents, x-ray diagnostic media and other pharmaceutical products.

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Michigan Medical Service

OVER ONE MILLION SUBSCRIBERS!

"One of the solid rocks upon which the entire Blue Shield movement rests," was the description of Michigan Medical Service given by Paul R. Hawley, M.D., Chief Executive Officer of the Blue Cross-Blue Shield Commissions, in presenting a testimonial plaque to this state's medical service organization.

Speaking before the annual convention of the Blue Cross and Blue Shield Plans at French Lick, Indiana, in October, Dr. Hawley awarded the citation to Michigan Medical Service to commemorate its being the first Blue Shield Plan to enroll a million subscribers, a mark which was reached last April.

How many is a million persons? Dr. Hawley pointed out that Michigan Medical Service subscribers now number more than the combat troops used by General Eisenhower in the Normandy invasion and more troops than General MacArthur used in the Philippines.

"This is a great achievement," he said, "but we have come to regard Michigan Medical Service as a plan of great achievements. It is one of the solid rocks upon which the entire Blue Shield movement rests. It is one of the trustworthy anchors that has held Blue Shield steady in stormy weather."

Michigan Teacher Honored

In presenting the plaque to R. L. Novy, M.D., President of Michigan Medical Service, who accepted the citation on behalf of the organization, Dr. Hawley made eloquent reference to Dr. Novy's father, one of Michigan's celebrated teachers of medicine.

Introducing Dr. Novy as "the distinguished son of an illustrious father," Dr. Hawley declared:

"I take added pleasure in presenting the President of Michigan Medical Service who will accept this plaque. I was a student of medicine in the early days of the entry of science into medicine. Among the teachers of medicine of that day there were a few giants who towered above the others. Schools of medicine were distinguished by the names of these leaders, rather than by the general measure of excellence of their curricula. Prominent among the giants of my student days was Novy of Michigan, whose name will be forever linked to man's knowledge of the anaerobic bacteria. I am happy to learn that he is still with us and in good health."

PAUL R. HAWLEY, M.D., Chicago, Chief Executive Officer, Blue Cross-Blue Shield Commissions, on the left, presents R. L. NOVY, M.D., Detroit, President of Michigan Medical Service, with a testimonial plaque, marking the achievement of the enrollment of a million subscribers by Michigan Medical Service. Looking on are L. HOWARD SCHRIVER, M.D., Cincinnati, President of Associated Medical Care Plans and JAY C. KETCHUM, Detroit, Executive Vice President, Michigan Medical Service.

President Novy Praises Profession

Praising the medical profession of Michigan for its leadership in creating and sponsoring a voluntary medical care plan that has deservedly attracted the attention of medical men throughout the country, Dr. Novy declared in accepting the citation:

"This is an achievement which has come about by the combined efforts of the medical profession, of Michigan Hospital Service, our Blue Cross Plan, and of the staff of Michigan Medical Service."

Officials of Michigan Hospital Service and Michigan Medical Service attending the meeting who were introduced by Dr. Novy were E. D. Barnett, M.D., President, and William S. McNary, Executive Vice President of Michigan Hospital Service; Jay C. Ketchum, Executive Vice President, Gordon Goodrich, Assistant Director, and John Castellucci, Director of the Veterans Program of Michigan Medical Service.

Cancer Comment

THE ANSWER TO CRITICAL LAYMEN

At many meetings of laymen, where the control of cancer is considered, two questions invariably arise very early in the discussion. One of these has to do with the unwillingness of some physicians to make a medical examination to discover or rule out cancer in an apparently well individual. The other question is whether the general practitioner can recognize cancer when making the examination. Such criticism and doubt on the part of lay individuals may occasionally be justified but in the main are entirely unwarranted and based on lack of understanding of the cancer problem.

Regarding the first of these questions it undoubtedly is true that some physicians, for reasons best known to themselves, brush aside a patient's request for examination with the remark: "You look well, you have no symptoms; forget about cancer and come back if or when you feel ill." Such an attitude is damaging to the physician and to the entire medical profession. Certainly the healthy person who wants to remain well and who is concerned enough with health to consult a physician before he becomes ill, is entitled to as much consideration as the patient who ignores medical educational efforts until in an advanced stage of disease before he seeks medical assistance.

The explanation put forth by such physicians is that requests for cancer detection examinations often come during busy office hours when responsibility to sick patients does not permit of adequate time being devoted to such an examination. In a measure this may be a legitimate excuse but one which can be overcome by making the examinations at a mutually convenient time. With advance appointments, many such examinations can be worked in during office hours as the physicians of Hillsdale County are amply demonstrating in carrying out the "Hillsdale Plan for Tumor Detection." The physicians of that county are averaging 100 examinations per month during office hours.

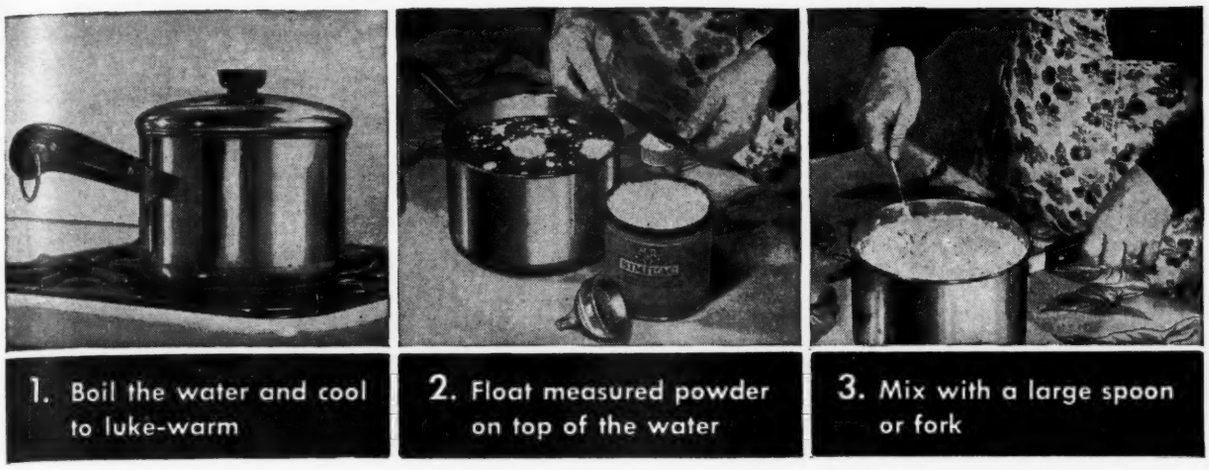
The physician who considers every patient asking questions about health or disease as a neurotic is making a serious mistake. Too few physicians, busy with their day-by-day problems of medical care, realize the extent to which the intelligent public has become informed about health problems including cancer. Some of this information should be labeled "misinformation" or "inadequate" and of no value to the cause of health education. However, much of it is sound and its full value to the community will depend on the part played by the physician in interpreting it to his community.

Physicians everywhere should remember that the public is constantly being told to have a periodic examination to find cancer in early and curable stages. Fifteen cancer detection centers are operating throughout the State of Michigan to furnish these examinations. While they represent a step in the right direction, these centers make demands on a physician's time which could be employed to better purpose if these examinations were made in his own office. (e.g. every doctor's office a cancer detection unit.) Physicians should remember that the public interest in cancer is such that more and better service is being demanded.

The second problem mentioned above is tied in closely with the one just discussed. Many laymen interpret the lack of a physician's interest in making examinations as an effort to conceal his inability to recognize cancer. This impression has also been fostered—probably unintentionally—by some of the lay educational effort stressing the difficulties underlying the diagnosis and proper treatment of certain cancers. This assumption that the family physician cannot diagnose cancer has led to the impression that a much more worthwhile examination can be given in a detection center than in a physician's own office. The detection center atmosphere seems to lend ability to the physician which he does not appear to possess within the confines of his private office. The mere fact that a physician leaves his office to enter a building across the street—the location of the cancer detection center—in no way increases his diagnostic ability. He *can* diagnose cancer and he *can do it* in his own office. Of equal importance is the fact that, by permitting the physician to render this service in his office, these examinations *can* be offered to countless more patients.

Cancer detection centers are making valuable contributions to the control of cancer. However, their chief value lies in the demonstrations they give to the medical profession and the public that cancer can be and is being found in early and curable stages by the examination of apparently well individuals. The physical limitations on these centers preclude their being the answer to the physical examination problem in any community. *This answer can come only by making every physician's office a cancer detection center.*

The Cancer Control Committee urges all Michigan physicians to study their local cancer problems, and to aid in their solution.



1. Boil the water and cool to luke-warm

2. Float measured powder on top of the water

3. Mix with a large spoon or fork

SIMILAC FEEDINGS ARE Easy TO PREPARE

It takes only 30 seconds to induce solution *if the powder is floated on top of the water*. Lukewarm, boiled water is desirable.

No need to mix several ingredients—hence the possibility of errors in measurement is greatly reduced.

The ratios of fat, sugar, and protein, *and the zero curd tension*, remain constant regardless of concentration . . . Therefore, no gastrointestinal disturbance will normally occur, should the mother err occasionally in counting the number of measures of Similac powder.

The level tablespoon measure in each can eliminates the possibility of underfeeding or overfeeding due to varying sizes of "tablespoons."

Result: **Similac reduces dietary disturbances traceable to mothers' errors in preparation of the formula**

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SIMILAC . . . a dependable food during the all-important first year

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Political Medicine

TRUMAN'S PROGRAM

1. Repeal of the Taft-Hartley act.

2. Expansion of social security coverage with benefits at least 50 per cent higher.

3. Enactment of a national program embracing compulsory health insurance.

4. Passage of the controversial civil rights program, the advocacy of which cost him four southern states.

5. Farm price supports and other agricultural legislation.

SCHOOL TEXTBOOKS

It will be recalled that not long ago many government agencies, such as the United States Public Health Service, were placed under the Federal Security Administration. Henceforth, all policies of any of these agencies must be cleared through the Federal Security Administrator before publicity can be given. Because of serious differences of opinion, Mr. Studebaker, long time head of the Department of Education, resigned. Portions of textbooks were read to illustrate the infiltration of the ideas of socialized medicine into the school books that are studied by junior high school students. For instance, in a text entitled, "We Are the Government," you may read this statement: "We are a democracy like Switzerland, Liberia and the U.S.S.R." Even arithmetic books have been rewritten so that questions pertaining to apples have been changed to problems on hospital expenses, medical care, et cetera. From a ninth grade arithmetic text were cited examples of problems pertaining to the average income of a physician in contrast to the income of persons in other walks of life, of the high cost of medical care to the average citizen. Ninth graders in public schools of America today are computing the percentage of the working man's total income that goes into the pockets of physicians, using as a basis the statistics that the Federal Security Administration chooses to give them.—Editorial, *The Journal of the Kansas Medical Society,* page 426, October, 1948.

TWO WIGS AND LOTS OF TEETH

"Aneurin ("Nye") Bevan, Britain's Health Minister, was a bit embarrassed last week by the public's enthusiasm for government-financed doctoring. He announced: 'It seems that an extraordinary proportion of the population has bad sight. . . . The health service will fail unless the people use it intelligently, sparingly and prudently.' "

"Oysters & Champagne.—How were the British faring with the National Health Service Act, now almost four months old?

"Some patients were running doctors ragged with petty requests. ("I always use Carter's Little Liver Pills. Please can I have a chit so that I can get them free?") A few diehard doctors, still hoping that the act would be a bust, were blandly prescribing champaigne, oysters, whiskey and rum for their patients—at government expense. Some patients were unreasonable. One physician, forced to cancel his evening office hours because of a difficult, ten-hour delivery, was greeted at his surgery next morning by four threatening hoodlums; he was now a servant of the people, they told him, and he had no right to be away during regular working hours. Some doctors were unpleasant. One, called five miles on a case, berated and lectured the parents of a sick child: "This is a fine thing, all this way in my car on the free service."

"The British (about 95 per cent have signed up) were taking advantage of their chance to get medical care and let the government pay the doctor's bill. A check in Birmingham showed that 97 per cent of the people tested actually needed glasses, and manufacturers of frames are two months behind in their orders. Two-thirds of Britain's dentists have signed up under the act; many are swamped with drill-and-forceps work on the notoriously bad British teeth.

"The act has created its own legends. A puzzle still unsolved by the Ministry of Health: the case of the dentist who pulled two of his own teeth, and sent in a claim for payment to himself. Last week* a butcher in Dudley, Worcestershire, asked for three pairs of eyeglasses: one for reading, one for looking at far-off things, one for chopping meat. He got them. In Cambridge, an elderly

(Continued on Page 1324)

*Also last week the act paid for delivery of its first quadruplets.

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Tempting, natural source of complete protein

6 varieties:
Beef, lamb, pork, veal, liver, heart

The things some patients on soft, smooth diets have to eat! It's no wonder appetites lag.

To perk up patients' interest in foods, many doctors now prescribe specially prepared Swift's Strained Meats when soft foods are indicated in a high-protein, low-residue diet. They help two ways. *One*, Swift's Strained Meats taste so good. Few patients can turn down real meat goodness. *Two*, an excellent source of B vitamins, Swift's Strained Meats help restore patients' natural appetite for all foods.

Originally prepared for infant feeding, Swift's Strained Meats are soft, smooth (may easily be used in tube-feeding), slightly salted—cooked to retain all their delicious meat flavor. Six kinds for variety: beef, lamb, pork, veal, liver, heart. Each one 100% meat, they provide an excellent, palatable source of complete, high-quality proteins and hemapoietic iron. These meats make available *simultaneously* all known essential amino acids . . . for optimum protein synthesis. Convenient — Swift's Strained Meats are ready to heat and serve.

The makers of Swift's Strained Meats invite you to send for your copy of "The Importance of Protein Foods in Health and Disease"—a physician's handbook of protein feeding, written by a doctor. Send to:

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For patients who can take foods of less fine consistency —Swift's Diced Meats offer tender morsels of nutritious meat with tempting flavors patients appreciate.

TWO WIGS AND LOTS OF TEETH

(Continued from Page 1322)

woman, bald since the age of six, asked for a wig. Ruled S. W. Davis, the pensions officer: "She will be provided with two wigs, as one occasionally has to be cleaned."

"Pounds and Pence.—What is it all going to cost? Britain is now paying general practitioners a total of £45,000,000 ($180,000,000) a year. The prewar total income of G.P.s: £28,000,000 ($112,000,000). But general practitioners are only part of John Bull's medical bill. Meanwhile, the Health Ministry and those who oppose socialized medicine are busy hurling statistics at each other. The British Dental Association claims that the plan is costing the government seven times the estimated cost for dentistry. Not so, says Bevan: the estimated £7,000,000 ($28,000,000) will nicely cover the first nine months.

"Many doctors who vainly fought the act through the British Medical Association (*Time,* March 1) remain unconvinced. The Labor Government was smart, grumbles the B.M.A. unofficially, in starting the service in July, when sickness rates are lowest: just wait until winter epidemics start jamming the doctors' already crowded offices."—*Time,* November 1, 1948.

NATIONAL HEALTH SERVICE

At the time of the April plebiscite the Council of the British Medical Association issued a document to every member of the profession setting out the changes which the Minister proposed to make in the National Health Service Act in response to the profession's representations. In this document (*Supplement,* April 24, p. 105) it was reported that the universal basic salary would be abandoned and that the Minister intended to limit it to principals during the first three years of practice, with an option to all other principals. Where basic salary was agreed, capitation remuneration would be reduced by one-seventh.

The Minister further agreed to discuss with the profession the conditions and methods of opting, so as to meet the Association's points that basic salary should be paid only where there was need and, except in such circumstances, should not provide a means of opting for higher remuneration per patient.

The fixed annual payments of £300 are credited to the recipients as a first charge on the local pool allocated to each executive council. This means that wherever a basic salary is paid to a practitioner with less than 2,200 public patients on his list an additional payment is being made to such a practitioner by his colleagues in the area.

After further discussions with the Ministry the regulations relating to the grant of basic salary were amended to provide that the local executive council, after consultation with the local medical committee, must decide on every application whether there was reasonable justification for a basic salary.—*British Medical Journal,* Oct. 2, 1948.

THE OREGON CASE

UNITED STATES OF AMERICA, Plaintiff

SUMMONS

Oregon State Medical Society, Oregon Physicians Service, and eight listed County medical societies and eight individual physicians.

There follows the complaint, jurisdiction and venue, defendants, definitions, nature of trade and commerce, constituting thirty paragraphs.

We now quote

V. OFFENSES CHARGED

31. Beginning on or about January 1, 1936, and continuing thereafter up to and including the date of filing this complaint, the defendants have attempted to, and have been engaged in a combination and conspiracy to, restrain and monopolize interstate trade and commerce in the business of selling and furnishing prepaid medical care in the state of Oregon and in other states, in violation of Sections 1 and 2 of the Sherman Act (15 U.S.C., Sections 1, 2). Defendants threaten to continue such offenses and will continue them unless the relief hereinafter prayed for in this complaint is granted.

32. The conspiracy has consisted of a continuing agreement and concert of action among the defendants, the substantial terms of which have been that defendants agree:

(a) To monopolize and attempt to monopolize prepaid medical care business in the State of Oregon and between the State of Oregon and other states.

(b) To limit the scope of medical care to be provided by prepaid medical care plans in the State of Oregon.

(c) To prevent, hinder, and obstruct prepaid medical care organizations other than those sponsored by defendants from continuing to engage in or from engaging in the business of selling and furnishing prepaid medical care in Oregon and in other states.

(d) To restrain residents of Oregon and other states from entering into or continuing under prepaid medical care plans not sponsored or supported by the defendants.

(e) To prevent doctors from co-operating in prepaid medical care plans not sponsored or approved by defendants.

(f) To restrict the use of hospital facilities by doctors co-operating in prepaid medical care plans other than those sponsored or approved by defendants.

(g) To prevent Oregon hospitals from allowing their facilities to be used by doctors and patients associated with prepaid medical care plans other than those sponsored or approved by defendants.

33. The combination and conspiracy herein above described and the intended restraints which have resulted therefrom have been effectuated in the following manner and by the following means:

(a) Defendants have hindered and obstructed prepaid medical care organizations in their attempts to procure and retain qualified doctors to co-operate with them.

(b) Defendants have expelled, threatened, and incited the expulsion from medical societies of doctors co-operat-

(Continued on Page 1326)

THE OREGON CASE

(Continued from Page 1324)

ing in prepaid medical care plans other than those sponsored or approved by the defendants.

(c) Defendants have formed and promoted their own prepaid medical care plans with the intent to drive out, hinder, and obstruct other commercial medical care plans operating in the state of Oregon.

(d) Defendants have interfered with commercial prepaid medical care organizations other than those sponsored or approved by them in obtaining hospital facilities for their members.

(e) Defendants have refused to treat patients and have caused others to refuse to treat patients who are members of a prepaid medical care plan not endorsed by defendants unless the patient pays cash.

(f) Defendants have refused and encouraged other doctors to refuse to give patients who are members of a prepaid medical care plan not endorsed by defendants itemized statements that will enable the patient to be reimbursed under the plan to which he has subscribed.

(g) Defendants have refused to consult or assist and have encouraged others not to consult or assist doctors who treat members on a prepaid medical care plan not endorsed by them.

(h) Defendants have spread false propaganda among doctors, hospitals, and the general public for the purpose of discrediting any prepaid medical care plans not endorsed by them.

(i) Defendants have agreed among themselves and with others not to compete with each other for prepaid medical care business or with other similar organizations approved by or affiliated with them.

(j) Defendants have succeeded in making hospital facilities in Oregon available only to members of defendant Oregon Medical Society and its component county medical societies, and have restricted and excluded other qualified doctors co-operating in prepaid medical plans other than those sponsored or approved by defendants from access to such facilities.

34. Each of the individual defendants has been active individually and as an officer or member of defendant associations or corporations in the violations herein alleged.

VI. EFFECTS OF VIOLATIONS

35. The following effects, among others, have resulted from the violations aforesaid.

(a) Prepaid medical care organizations other than those sponsored by the defendants have been prevented and hindered in entering into or expanding their business in Oregon. The business of such organizations outside the State of Oregon has been impeded and their ability to do business outside Oregon has been impaired.

(b) The public in and out of Oregon has been deprived of a fair and free opportunity to acquire prepaid medical care insurance from organizations competing with one another in a free market.

(c) Members of the public in and out of Oregon have been deprived of medical care, which, save for the restraints herein described, would have been afforded them.

(d) Business concerns in and out of Oregon have been deprived of the opportunity to obtain prepaid medical insurance for their employes in an unrestrained market, and their business within and outside the State of Oregon has been adversely affected thereby.

(e) Doctors have been deprived of an opportunity to practice medicine in Oregon on terms of their own choosing, pursuant to the laws of Oregon.

(f) Doctors in Oregon and outside of Oregon have been denied the use of hospital facilities in Oregon.

(g) Hospitals in Oregon have been denied the privilege of making their facilities available to doctors and members of the public.

(h) The market for the sale and distribution of medicines, drugs, medical supplies, and medical equipment has been unduly restricted.

VII. PRAYER

Wherefore plaintiff prays:

(1) That pursuant to Section 12 of the Clayton Act, an order be made and entered requiring such of the defendants as are not residing within this district to be brought before this Court in this proceeding as parties defendant, and directing the Marshals of the District in which they severally are inhabitants, or may be found, to serve summons upon them;

(2) That the combinations and conspiracies in restraint of interstate trade and commerce, together with the attempts to monopolize, conspiracy to monopolize, and monopolization of the same, hereinbefore described, be declared to be illegal and violative of the Sherman Act;

(3) That defendants be perpetually enjoined from further engaging in or carrying out said restraints and conspiracy, from doing any act in furtherance thereof, and from engaging in any similar conspiracy or course of conduct;

(4) That defendant medical societies be perpetually enjoined from refusing to take into their membership, and from expelling or threatening to expel from their membership, any doctor because of his co-operation in medical care plans other than those sponsored or approved by the defendants;

(5) That defendant medical societies, upon application or request therefor by any such doctor, shall reinstate as a member in good standing any doctor who has been expelled from membership because of his co-operation in a medical care plan other than those sponsored or approved by the defendants;

(6) That defendants be perpetually enjoined from persuading or inducing or attempting to persuade or induce hospitals to discriminate in the use of their facilities against doctors or patients co-operating or associated with medical care plans other than those sponsored or approved by defendants;

(7) That defendants be perpetually enjoined from persuading or inducing, or attempting to persuade or induce doctors not to co-operate in medical care plans other than those sponsored by the defendants;

(8) That the defendants be perpetually enjoined from suggesting, advocating, or agreeing that doctors should refuse to treat patients who are associated with medical care plans other than those sponsored or approved by the defendants; or to discriminate against said patients with respect to fees charged for medical services; or discriminate against said patients by requiring them to pay cash for medical services; or refuse to supply itemized statements to said patients showing the medical services rendered and the fees charged therefor;

(9) That defendants be perpetually enjoined from the publication or dissemination of false or disparaging publicity concerning medical care plans other than those sponsored or approved by the defendants;

(10) That defendants be perpetually enjoined from advocating, inducing, or agreeing that doctors who are

(Continued on Page 1422)

Further evidence of the safety of Benzedrine Sulfate therapy

More data, showing that Benzedrine Sulfate, in proper dosage, produced no toxic effects, have lately been published in a study by Caveness.[1]

He gave the drug for 14 consecutive weeks to 23 unselected hospital patients whose ages *averaged 65 years.* Daily dosages over the period ranged from 5 to 30 mg. The author observes:

"... no significant changes were noted in the cardiovascular, urinary, hematopoietic, or respiratory systems ..."

From this study, it would appear that Benzedrine Sulfate may be safely used in the treatment of depression in the aged.

1. New York State J. Med. 47:1003

Benzedrine* Sulfate tablets • elixir

(racemic amphetamine sulfate, S.K.F.)

one of the fundamental drugs in medicine

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

PR in Practice

Lawmakers Convene January 2

The next session of the Michigan State Legislature will officially open January 2, 1949. Once again the members of the Michigan State Medical Society must be on the alert to see that the best interests of the people are served. Among the subjects that will be of interest to the medical profession during the coming year will be the reimbursable cost formula for hospitals, the practical nurse licensure law, the Hospital Act for mentally diseased persons, the proposed Vocational Rehabilitation Bill, and the proposed amendments to the Social Welfare Act, et cetera.

PR and Secretaries Conference Slated for January 9

The Public Relations and Secretaries Conference will be held Sunday, January 9, at the Book-Cadillac Hotel, Detroit. The conference will be attended by members of the MSMS Public Relations Committee, County Medical Society Public Relations Committee Chairman, and County Secretaries. Approximately 200 are expected to attend.

Medical Associates Brochure Warmly Received

Distribution of the Medical Associates brochure is well under way. Copies have been sent to the American Medical Association for distribution to other state and major county medical societies. It has also been sent to hospitals and schools throughout Michigan. Many requests for this booklet received by the MSMS executive offices have been filled. All of the comments on the brochure received to date have been highly complimentary, and the newspapers of the state have given the program excellent publicity.

"Lucky Junior" Gains National Recognition

The MSMS motion picture "Lucky Junior" has been shown in over 100 Michigan communities to date, has been scheduled for showing in 250 theaters, and will ultimately be presented in 400 theaters throughout this state. Its reception has been uniformly excellent. Letters have been sent to doctors inquiring when the picture will be shown in their vicinity, and publicity has been given by special news releases to newspapers in the locality where "Lucky Junior" is shown.

Outstanding nation-wide publicity has also been received on this picture with stories being carried in more than 300 educational journals as well as in trade magazines of the motion picture industry. Additional publicity has been carried in PR publications and in general letters to medical leaders distributed by the American Medical Association.

Sex Education Transcriptions Near Completion

Dramatized transcriptions of the MSMS sex education scripts are being developed by Wayne University. Half of these platters are scheduled for completion by January 1 and the remaining half by February 1. By following this schedule it will be possible to introduce the series in the Lansing public schools for the second semester preparatory to general statewide distribution next fall.

Magazine Article Lauds MSMS Rheumatic Fever Campaign

Birt Darling of the *Lansing State Journal,* in cooperation with the MSMS PR office, prepared an article on Michigan's campaign against rheumatic fever which was published in the November issue of *Science Illustrated* magazine. This story, which has been commented upon throughout the country, has evoked much interest in the MSMS's Rheumatic Fever Control program.

Detroit Pharmaceutical Firm Sponsors "Tell Me Doctor"

The J. F. Hartz Company, a Detroit pharmaceutical firm, has contracted to sponsor the "Tell Me Doctor" program over CKLW, Detroit, for a year's time. The radio time alone will represent an investment of $10,000 by Hartz.

Four Michigan Representatives Attend AMA PR Conference

Four representatives from the Michigan State Medical Society attended the American Medical Association Public Relations Conference in St. Louis, Missouri, November 27, including W. E. Barstow, M.D., St. Louis, Michigan, President-Elect; J. S. DeTar, M.D., Milan, Speaker; Wilfrid Haughey, M.D., Battle Creek, Editor; and Hugh W. Brenneman, Public Relations Counsel. The delegates, following a welcoming address by George F. Lull, M.D., AMA Secretary, participated in a "Problem Clinic" and a question and answer period dealing with the PR aspects of organized medicine.

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Rheumatic Fever and the School Child

By George M. Wheatley, M.D., M.P.H.
Assistant Vice President
Metropolitan Life Insurance Company
New York City

THE SCHOOL occupies a unique position in relation to rheumatic fever control. Rheumatic fever causes more deaths than any other disease in children of school age. A first attack usually occurs in children at the age when they are in the first or second grade and recurrences are most common up to the age when children are leaving high school. The insidious onset of so many cases during the school years suggests that teachers and others in daily contact with school children should be aware of early signs and symptoms which may mean acute rheumatic fever.

The periodic school health examination when done hastily without removal of clothing may miss children with rheumatic heart disease. On the other hand, children may be labeled with the diagnosis of a rheumatic heart because a heart murmur was wrongly interpreted. This serves to emphasize the opportunities as well as the difficulties of discovering rheumatic fever and rheumatic heart disease in school children.

The problem of what to do about rheumatic fever through the schools is an integral part of what should be done about the health of all school children. The following recommendations, while pointed towards case-finding and health supervision of the rheumatic child, will, if applied, lead to better health service for all school children.

Improvement of the School Medical Examination

The periodic school medical examination should be improved:

1. By obtaining a health history of the child from the parent and the teacher, if possible, at the time of the child's examination.
2. By being performed without haste and with the child disrobed.
3. By the employment of physicians trained in pediatrics, if possible. Where this is not feasible, arrangements should be made for giving physicians who make school medical examinations additional clinical training in normal child growth and development as well as in children's medical problems including rheumatic fever and heart disease.
4. By allowing time for the physicians to plan with the nurse and parent for medical attention. The examination is then more likely to be of greater aid in getting medical care for school children who need it.

The following activities of the nurse should be to see that the children in need of medical attention are referred to physicians and that every effort is made to have needed care given. Special health and welfare resources in the community should, if necessary, be brought to the attention of the family and the child's physician.

Daily Observation of Children with Special Reference to Rheumatic Fever

Nurses and teachers should be more alert to substandard health in all school children. School absence due to illness or vague disorders, if investigated, may disclose early cases of rheumatic fever. In order to make use of the school's daily contact with the child, there should be daily observation of pupils for signs and symptoms suggestive of

substandard health. Among these signs and conditions which should bring children to the attention of the teacher or parent are:

1. Failure to gain weight
2. Pallor
3. Fatigue
4. Frequent colds and sore throats
5. Tonsil and adenoid operations (because it may indicate previous sore throats)
6. Scarlet fever or any known streptococcus infection
7. Unexplained nosebleeds
8. Unexplained fever
9. Poor appetite
10. Pains in arms, legs, and joints
11. Unusual restlessness, irritability or twitching or jerky motions
12. History of previous rheumatic fever
13. Behavior and personality changes
14. Decreasing accomplishments in school by a child who previously has done well

Children reported by the teacher as showing evidence of substandard health should be medically reviewed by the school nurse or physician, to select children who need further medical investigation. A personal interview by the school physician or nurse with parents either in school or through a home visit is recommended, to emphasize the need for further medical attention for the child through the physician of the family's choice.

Schools have tended to place too much emphasis on the finding of a heart murmur in the child. This has resulted many times in needlessly restricting the child's physical activities.

Relatively few rheumatic children attending regular school in the intervals between attacks need to have their physical activity restricted. In a group of 1,000* rheumatic children seen ten years after they first came under observation, 783 were alive and, of these, more than 80 per cent were able to lead normal active lives except in competitive sports. More than half were able to engage in competitive sports.

Preparation of Teachers in Health Guidance

Teachers should know more about children's health problems, including rheumatic fever. Not only should they be able to recognize children with signs and symptoms of substandard health, but also they should realize the importance of protecting children, especially the rheumatic child, from respiratory infections. Children with early signs of upper respiratory infections should be encouraged to stay home. Health education is especially important for the rheumatic child because the chronic nature of the disease requires, as in tuberculosis, that the susceptible individual learn the special importance of good hygiene. Preparation in health guidance should be given both to teachers in training and to teachers in service.

Rheumatic Fever Diagnostic Service

Because of the difficulty of diagnosing rheumatic fever and rheumatic heart disease, and especially the important point of determining whether or not the process is active, special diagnostic facilities should be available to all physicians, including school physicians, who may advise parents concerning care of children with possible, potential, or definite rheumatic heart disease. Diagnostic facilities should have the approval of local medical societies. The consulting specialist in rheumatic fever should have electrocardiographic, fluoroscopic, and other necessary laboratory facilities. Every effort should be made to bring this diagnostic service to the attention of physicians who take care of school children. A complete report of the specialist's examination should be sent to all physicians concerned with the care of the child.

The purpose of this service is not only to diagnose rheumatic fever and rheumatic heart disease and to make recommendations as to the health and educational services needed by the child, but also to screen out those children who have heart murmurs but who do not have organic heart disease. It is also useful in regard to placement and removal of children in special schools and classes for the handicapped.

Co-operation with Community Health and Welfare Agencies

Adequate health services for school children call for close working relationships between medical, public health, social welfare, and educational authorities. The school can improve its services to children by utilizing, at every opportunity, community resources—for example, the use of the clinical teachers of a local medical school to give courses to school physicians, the use of laboratory and clinic services of community hospitals for diagnostic and consultation service; the provision of home or hospital education for children who are bedridden; communication with welfare authorities concerning inadequacies in the home environ-

*Jones, T. D., and Bland, E. F.: Rheumatic fever and heart disease; completed ten-year observations on 1,000 patients. Tr. A. Am. Physicians, 57:265-270, 1942.

ment. These services should be made available to all, but without waste of professional services and of public funds. Close co-operation between the physician, family, school, and other community health and welfare resources is essential.

Summary

The school gives an unusual opportunity to attack rheumatic fever. Certain improvements in school health services are needed to make the best use of this opportunity. These recommendations will not only be a better approach to rheumatic fever but to other health problems of children. The alertness of teachers and school nurses can bring to medical attention children with signs and symptoms suggestive of rheumatic fever whose condition might otherwise be overlooked. It is also an opportunity through periodic medical examinations to discover unrecognized damage to the heart and keep under medical supervision known cases of the disease and to make family studies of rheumatic children. It is an opportunity to teach the principles of healthful living to children who have the disease or who are susceptible.

To aid school health authorities to develop a more rational approach in the control of this disease, it is proposed that (1) the school medical examination be improved to aid in more accurate recognition and supervision of rheumatic children, (2) more emphasis be placed on referral by teachers and nurses of pupils believed to be below par for medical review, (3) less emphasis be placed on restricting the physical activity of rheumatic children and more attention given to daily observation of pupils for signs or conditions suggestive of rheumatic fever, (4) there be available to school health services and the practitioners diagnostic and consultation services to establish diagnosis, (5) these services be developed in co-operation with, and by utilization of, existing medical and public health resources in the community.

MSMS

BLOOD SUGAR AND ANGINA

Patients with angina pectoris do not tolerate a low blood sugar level; hence it is important not to overtreat diabetes. It is better for such patients to spill some sugar in their urine than to run the risk of too low a blood sugar level by seeking perfection in diabetic management either by too strict a diet or too much insulin.—Treatment of Heart Disease by William A. Brams, M.D.

Diagnostic Aids in Rheumatic Fever

By Charles A. R. Connor, M.D.
New York, N. Y.

RHEUMATIC FEVER, although a very common disease in childhood and one responsible for more deaths in this period of life than any other disease, is often difficult to diagnose. No uniform diagnostic criteria have been established.

Rheumatic heart disease is easier to recognize and definite criteria have been established and accepted.[2] There are, however, an appreciable number of children and young adults with abnormal cardiac signs or symptoms in whom a diagnosis of heart disease is uncertain. They are classified as Possible Heart Disease. If such individuals have had a recent attack of rheumatic fever they are then classified as Potential and Possible Heart Disease.

The diagnosis of acute rheumatic fever and rheumatic heart disease are two separate problems, even though there is good evidence to show that the heart is invariably affected during the acute stage of the disease. In a considerable number, one-half to one-third, the lesion in the heart will either heal completely or the residual will be of such a microscopic nature as to be of no clinical significance.

The manifestations of rheumatic fever vary in different age groups. The diagnosis is most difficult in early childhood because of the high incidence of carditis and of vague and bizarre joint and muscle sypmptoms. In early adult life that diagnosis is simpler due to the occurrence of the typical migratory polyarthritis. This is particularly true in the northern half of this country.

When the stage of active rheumatic infection subsides, there may be a latent stage of activity indeterminable by present clinical and laboratory tests. It is not uncommon to have definite signs of rheumatic heart disease appear during this period.

Certain minimum diagnostic facilities and equipment are essential. These include a quiet room with an examining table, a modest laboratory, with a technician capable of performing complete blood counts and erythrocyte sedimentation rates, x-ray equipment, preferably a fluoroscope,

and an electrocardiograph. The value of each of these facilities varies with the stage of rheumatic fever. The training and experience of the physician using these tools is obviously the *sine qua non* of any case-finding method.

In any suspected case of rheumatic fever the diagnosis, especially in children, will often depend upon finding evidence of carditis. Carditis is the first of five major manifestations of rheumatic fever in the diagnostic criteria suggested by Jones. Carditis can be diagnosed if the patient develops: cardiac enlargement; significant heart murmurs; pericarditis; or congestive heart failure. Certain electrocardiographic changes in the presence of other manifestations of the disease are also helpful in verifying its presence.

In addition to carditis, other major manifestations are arthralgia; chorea; subcutaneous nodules; and a verified history of previous rheumatic fever. All of these manifestations require less in the way of additional diagnostic equipment than carditis, as they are largely determined by the history and physical examination.

Seven minor manifestations of rheumatic fever are: fever; abdominal pain; precordial pain, erythema marginatum; epistaxis; pulmonary changes; and certain abnormal laboratory findings.

A combination of two major manifestations, or of one major and two minor manifestations would place the diagnosis of rheumatic fever on reasonably safe grounds according to Jones. The weakest combination of these manifestations to warrant a diagnosis of rheumatic fever would be arthralgia, fever and some abnormal laboratory finding usually hematologic.

It is evident that a diagnosis of heart disease—carditis during the active phase of rheumatic fever, or chronic valvular heart disease, indicating a previous attack of the disease—are of prime importance as both are major manifestations of the disease.

An enlarged heart is a diseased heart. Often this single and most important feature of a cardiac examination can be determined by inspection or by palpation of the chest wall. Sometimes an x-ray examination is necessary. Fluoroscopy, utilizing the frontal, right and left oblique views, plus visualization of the esophagus with barium is by and large the most valuable diagnostic aid. Progressive cardiac enlargement either as a whole or limited to certain chambers indicates active carditis. There is often difficulty in applying this diagnostic aid in the case of patients who are acutely ill.

In chronic rheumatic heart disease, the fluoroscopic study is the most important supplement to the physical examination. It is true that organic valvular heart disease, such as mitral stenosis or aortic insufficiency, can be present without any detectable enlargement of any chamber of the heart. The diagnosis of such valvular defects can be made satisfactorily on physical examination. In this regard the use of certain kinds of stethoscopes is helpful, as the Bowles type for high pitched murmurs like the characteristic murmur of aortic insufficiency and the bell-type for low pitched murmur of mitral stenosis. Certain special procedures for eliciting murmurs are equally important. The murmur of aortic insufficiency is best heard with a relatively slow heart rate, with the breath held in expiration and with the patient erect or bent forward. It is loudest in the third or fourth interspace at the left border of the sternum. The characteristic low-pitched diastolic rumble of mitral stenosis is localized at the cardiac apex. It is almost always louder when the patient is lying on his back or left side, especially after sufficient exercise to increase the heart rate to 100 or more per minute.

Much emphasis has been placed on the diagnostic value of the electrocardiogram. In the inactive stage of rheumatic fever and in chronic rheumatic heart disease it is of limited value.

In the active phase of rheumatic fever or in the cases in whom a suspicion of this disease exists electrocardiograms should be taken. Since a single electrocardiogram may show no abnormality, or may be only suggestive, it is desirable to obtain serial tracings at regular intervals. In recent years an unfortunate tendency has arisen to overread electrocardiographic tracings placing unwarranted significance on minor changes in the auricular or ventricular complexes of the record. A detailed analysis of the patterns that may be considered significant is not possible, but for the most part they are changes in the final ventricular deflections, prolongation of the auriculoventricular conduction time, or changes in rhythm. Prolongation of the electrical systole (Q-T interval) has been regarded as a sensitive index of active cardiac infection by some workers. This conclusion, however, is questioned by many.

Laboratory procedures such as blood counts and the sedimentation rate of the erythrocytes are usually helpful in determining the presence of an

active infection. Jones has classified them as minor manifestations since they are not specific for rheumatic fever. They are more pertinent in evaluating the presence of active rheumatic infection in a known case than as a diagnostic aid. The presence of a normal blood count and a normal sedimentation rate does not exclude the diagnosis of rheumatic fever. Normal sedimentation rates are not unusual in patients with severe carditis. In the inactive stage of rheumatic fever such tests are of no value.

Many other laboratory tests both clinical and immunologic have been proposed as an aid in the diagnosis of rheumatic fever. Some are misused, as the antistreptolysin values. A high titer merely indicates an infection with a hemolytic streptococcus in the immediate past. It may be of interest in following the course of the acute stage of the disease, but it is of limited value in the diagnosis. Numerous other tests have been proposed as substitutes for the sedimentation rate, but none of them are specific for rheumatic fever.

Summary

1. The diagnosis of rheumatic fever is often a difficult and time-consuming procedure by virtue of the fact that there is no specific clinical or laboratory test.

2. Accurate diagnosis requires training and experience. It is particularly difficult in cases which have their onset in early childhood. It this age period joint symptoms are often bizarre, and mild cardiac signs and symptoms may dominate the clinical picture. In the adolescent period the typical migratory polyarthritis syndrome is the commonest clinical manifestation and the diagnosis is easier.

3. Minimum diagnostic facilities are laboratory studies of the blood; x-ray, preferably fluoroscopy, and an electrocardiograph. All have certain limitations which have been discussed.

References

1. Jones, T. Duckett: The diagnosis of rheumatic fever, J.A.M.A. 126:481, 1944.
2. New York Heart Association: Nomenclature and Criteria for Diagnosis of Diseases of the Heart. 4th Edition. New York Heart Association, 1939.

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Eggs of fish and other eggs laid in the sea must be produced in enormous numbers if enough are to survive; one oyster sheds around 30,000,000 eggs in a single season. —*Science News Letter*, November 6, 1948.

Report of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction

American Heart Association

By Irving S. Wright, M.D., Charles D. Marple, M.D., Dorothy Fahs Beck, Ph.D.
New York, N. Y.

I. S. Wright, M.D.

THE POSSIBILITY of preventing the extension of coronary thromboses and the development of mural thrombi in the presence of myocardial infarction by the use of anticoagulants was suggested by Solandt, Nassim and Best[4,5] in 1938. These investigators were able to prevent the development of both coronary thrombi and of intracardiac mural thrombi under conditions in which such thrombi are usually produced experimentally in animals, by the use of the anticoagulant, heparin. Their observations were not applied to man on any significant scale because of the difficulties and the risk felt to be inherent in the use of heparin clinically. In the years 1945 and 1946, Wright,[6,7] Nichol and Page,[2] and Peters, Guyther and Brambel[3] reported encouraging results following the use of the anticoagulant, dicumarol, in the treatment of coronary thrombosis with myocardial infarction in man. These reports were perliminary in nature since only small numbers of cases were reported. However, the uniformly favorable results appeared to justify a more extensive study of the use of anticoagulants in the treatment of coronary thrombosis.

Accordingly, in the spring of 1946, the Board of Directors of the American Heart Association authorized the formation of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction. This committee is composed of internists with special interest in cardiovascular diseases associated with the sixteen hospitals which have contribut-

This study, a progress report on the statistical analysis of the first 800 cases studied by this committee, has been supported by grants from the U. S. Public Health Service.
Presented at the Eighty-Third Annual Session of the Michigan State Medical Society, Detroit, September 22, 1948.

ed cases to this study. Workers in several additional institutions have participated in an advisory or consulting capacity. The participating hospitals and the responsible investigators are as follows:

Participating Hospitals

Bellevue Hospital, New York.....John E. Deitrick, M.D.
Beth Israel Hospital, Boston..Herrman L. Blumgart, M.D.
Bronx Veterans Hospital.....Louis A. Kapp, M.D.
Cincinnati General Hospital.....Johnson McGuire, M.D.
Helen Glueck, M.D.
Cleveland City Hospital.....Roy W. Scott, M.D.
Henry Ford Hospital, Detroit.....F. Janney Smith, M.D.
Jackson Memorial Hospital, Miami.....
.....E. Sterling Nichol, M.D.
Lakeside Hospital, Cleveland....Joseph Hayman, Jr. M.D.
Massachusetts General Hospital.....
.....Howard B. Sprague, M.D.
Michael Reese Hospital, Chicago.....Louis N. Katz, M.D.
Mount Zion Hospital, San Francisco.....
.....John J. Sampson, M.D.
Pennsylvania Hospital, Philadelphia.....
.....Joseph V. Vander Veer, M.D.
Peter Bent Brigham Hospital.....Samuel A. Levine, M.D.
Rhode Island Hospital, Providence..Frank B. Cutts, M.D.
San Francisco County Hospital.....John J. Sampson, M.D.
The New York Hospital.....Irving S. Wright, M.D.
Harold J. Stewart, M.D.

Consultants

Ralph S. Overman, Ph.D.....Nelson W. Barker, M.D.
Charles E. Brambel, Ph.D.....Grace Goldsmith, M.D.

Central Laboratory

Irving S. Wright, M.D.....*Chairman of Study*
Charles D. Marple, M.D.....*Co-ordinator*
Dorothy F. Beck, Ph.D.....*Statistician*

Each investigator has been assisted by a team of residents, fellows and associates from his staff. Full credit must be accorded each of these workers whose wholehearted co-operation has been indispensable to the success of this study. It is a pleasure to report that one thousand cases with coronary occlusion and myocardial infarction have been studied under the conditions of this investigation.

Plan of the Study

Slightly fewer than one-half of these one thousand cases have been treated by conventional methods of therapy alone. The others have been treated with anticoagulants in addition to convention methods. A record of each case has been prepared in detail on master forms by the responsible investigator and his associates and forwarded to the Central Office of the committee at The New York Hospital. The master forms are being subjected to intensive statistical analysis and a definitive report on the 1,000 cases will be prepared as promptly as the analysis will permit. The present report includes data obtained from analysis of the first 800 cases reported to the Central Laboratory. Although it is possible that the addition of the last 200 cases, and other later revisions, may change the figures somewhat, it is unlikely that the conclusions will be altered significantly since the relationship of the control and treated groups as to deaths and thromboembolic complications has remained relatively stable as the sample has increased in size.

Three hundred and sixty-eight patients admitted to the participating services on *even* days received conventional therapy and constitute "the control group." Four hundred and thirty-two patients admitted on *odd* days received anticoagulants in addition to conventional therapy and constitute "the treated group."

The principles used as guides in the administration of dicumarol and heparin were as follows:

"(a) Heparin may be given for the first 48 hours or more if desired.

(b) Prothrombin determinations are to be done each day and no dicumarol should ever be ordered unless the morning prothrombin report is available.

(c) Dicumarol 200-300 mg. daily should be given until the prothrombin time is 30 seconds.

(d) Dicumarol 50 to 100 mg. daily should be given if the prothrombin time is between 30 and 35 seconds.

(e) Dicumarol is withheld if the prothrombin time is 35 seconds or more. Then, no drug is given until the prothrombin time is again down to 30 seconds or less, after which the drug is again given cautiously in 100 mg. doses.

(f) The Link-Shapiro technique, using undiluted whole plasma, or the Quick method is to be used for determining the prothrombin clotting time and it is suggested that the Link-Shapiro method using 12.5 per cent diluted plasma be employed as an additional check or safeguard. All prothrombin times are given in terms of the Link-Shapiro (undiluted) method.

(g) Unless contraindications arise, the dicumarol therapy is to be continued in the chosen cases over a minimum period of 30 days, preferably 30 days after the last thromboembolic episode.

(h) In instances of hemorrhagic manifestations, the use of synthetic vitamin K preparations in doses of 60-75 mg. and transfusions of fresh whole blood (may be citrated) are recommended."*

A comparison of the patients in the "control" group with those in the "treated" group shows a

*From the instructions issued to each participating team—slightly modified.

striking similarity in regards to age, history of previous infarction and estimated severity of the present attack. The average age of the control group of males was 58.9 years; that of the treated group, 57.2 years. For the females the average age of the control group was 64.1 years, and of the treated group, 64.6 years. In this series of 800 cases, the average for females was approximately 6.4 years older than that for the males.

Analyzing the two groups for a history of one or more previous infarctions, it was found that 24 per cent of the control group and 22 per cent of the treated group had had one or more previous infarctions.

An estimate of the severity of the attack was made for each patient at the time of diagnosis and recorded as mild, moderate or severe. Twenty-three per cent of the control group and 30 per cent of the treated group were classified as having severe attacks. Although this classification is admittedly arbitrary, the results suggest that the treated group contains a somewhat greater proportion of severely ill patients. The control and treated groups were also closely similar when the medical histories of cardiovascular diseases and the locations of their original infarcts were compared.

Eighty-eight per cent of patients in the control group received no anticoagulant, but twelve per cent did receive some anticoagulant therapy, often for short periods only. Anticoagulants were administered to patients in the control group following the development of a thromboembolic complication in three cases out of five, and in the remaining cases because of pressure on the part of the family or a private physician* or miscellaneous reasons. Of the treated group, 81 per cent received dicumarol only, while 14 per cent received dicumarol and some heparin. In three per cent of the "treated cases" no anticoagulants were given because of concurrent renal or hepatic disease or because of hemorrhagic conditions, and 2 per cent received no anticoagulant because of miscellaneous errors.

In the computation of the rates upon which all charts are based, small and conservative corrections were made in order to simplify the presentation. In the control group the rates are corrected for exceptions to the "no anticoagulant" rule. Rates as shown are those it is estimated would have occurred if no case in the control group had received any anticoagulant. They differ only slightly from the data as actually reported and are believed to present a truer picture of rates without anticoagulants. In the treated group the rates are corrected for erroneous omissions of anticoagulants. There is evidence that with more intensive and inclusive anticoagulant therapy, the rates for death and complications in the treated group would have been lower than those shown. No correction was made for those patients from whom anticoagulants were withheld because of specific contraindications. These omissions are considered to be disadvantages inherent to this type of therapy.* In both groups all rates for thromboembolic complications and hemorrhagic manifestations, as stated in this interim report, refer to conditions diagnosed clinically. Statistics based on autopsy findings are not yet available, but are being analyzed at this time.

Comparison of the death rates in the control group and in the group who received anticoagulant therapy, shows that 24 per cent of the control patients died, whereas 15 per cent of the treated patients died. Thus, somewhat more than one-third of the individuals who would have died without anticoagulant therapy survived the specific attack under consideration when anticoagulants were given. This difference is statistically significant.** Further examination indicates that the greatest improvement was achieved in patients who had suffered one or more thromboembolic complications prior to death. Such deaths occurred in roughly 10 per cent of the control cases, but in only three per cent of the treated cases. Death not preceded by a clinically recognized thromboembolic complication occurred in approximately 14 per cent in the controls as against 12 per cent in the treated group. As previously anticipated, anticoagulants reduced the death rate largely by reducing the incidence of those thromboembolic complications which, directly or indirectly, result in death.

*This factor became intensified as the study progressed.

*These corrections were made by assuming that if anticoagulants had been completely withheld from all control cases receiving anticoagulants they would have developed at least as many further complications and would have died at least at the same rate as did control cases of comparable age who received the anticoagulants at any time under approximately comparable circumstances. If actual rates for subgroups among these patients for whom exceptions were made did not already exceed these estimates, the estimates were substituted for the actual data for these particular subgroups. An appropriate modification of this correction procedure was applied in the case of the treated group and for hemorrhagic manifestations in both groups. The resulting corrected figures are portrayed graphically and referred to in the text without reference to the corrections or to the exceptions in treatment. *The corrections for exceptions proved to be small and sometimes were completely without effect on the rates. They do not alter at any point the basic differences between the groups from which conclusions are drawn.*

**The term statistically significant is used throughout the text to mean that the chances that two random samples from the same population would yield on the basis of chance alone differences as great as those observed and in the same direction are less than one in one hundred. In most instances the chances of obtaining these differences in two samples from the same universe are in fact very much less than one in one hundred—in the case of thromboembolic complications, less than one in a thousand.

The death rates by week of illness, were highest during the first two weeks, but were still considerable during the third and fourth week. For each period the death rate for the control patients was found to be significantly greater than that for the treated group. These figures indicate that anticoagulant therapy, if not used before, should be begun even as late as the second or third week after a myocardial infarction has occurred—or later if complications have developed, and, secondly, that, to give maximal protection, anticoagulant treatment should be continued for at least four weeks after the last thromboembolic episode.

The greatest benefits in the reduction of mortality are in patients 60 years or older. These statistics show that the therapeutic effect of anticoagulants is sufficiently important that they should be used in the older age groups. Hemorrhagic complications have been so few and so mild throughout the entire study and the benefits of treatment of the older age group are so pronounced that we do not hesitate to prescribe anticoagulants to older patients. It should be recognized however that older patients have a higher incidence of unrelated complications and that careful consideration of such factors in mandatory. While the crude death rates for patients under fifty-nine in both the treated and the control group, did not show a significant difference, the incidence of thromboembolic complications is high in these age groups, and the treated cases show a much lower incidence of thromboembolic complications. Such thromboembolic complications may not only be serious incidents in themselves, but they may result in such serious permanent disabilities as hemiplegia (following cerebral emboli), chronic venous insufficiency (following thrombophelebitis) or residual myocardial damage (following repeated myocardial infarction).

Percentage of Cases Developing One or More Thromboembolic Complications

Twenty-five per cent of the control cases in contrast to only 11 per cent of the treated cases developed at least one such complication. This difference is statistically significant. However, of these treated cases, 3.5 per cent developed their first complication before they had received anticoagulant* and 1.5 per cent developed their first thromboembolic complication during the first three days of anticoagulant therapy, before dicumarol is ordinarily fully effective. Thus, 5 per cent developed thromboembolic complications when anticoagulant therapy *could not* have been fully effective and only 6 per cent developed thromboembolic complications while they were actually under the full effect of anticoagulant therapy.

*Included in this group are those who never received anticoagulants because of contraindications.

Number of Thromboembolic Complications Per Hundred Cases

Among each one hundred cases in the control group, thirty-six thromboembolic complications were diagnosed clinically, whereas among each one hundred cases in the treated group, only fourteen thromboembolic complications were so diagnosed. In other words, the patients in the "treated group" experienced slightly more than one-third as many thromboembolic complications as did the control group, a contrast that is again highly significant statistically. This contrast is further emphasized by the following facts. It is noted that five thromboembolic complications per 100 cases developed while the patients were not receiving anticoagulant therapy, and 2.5 thromboembolic complications per 100 cases developed during the first three days of anticoagulant therapy when dicumarol is not considered efficacious. Actually, then, only 6.5 thromboembolic complications per one hundred treated cases occurred in patients who were under the full therapeutic effect of anticoagulant therapy. This figure includes complications in some patients whom we would not now consider to have been under adequate therapy at the time the complication occurred. Autopsies were conducted on 48 per cent of the patients dying among the 800. The autopsy records for these cases are being studied intensively and will yield further light on the effects of anticoagulant therapy on thromboembolic complications.

The highest incidence of thromboembolic complications among the control cases occurred in the age group between fifty and fifty-nine is distinct contrast to the death rate by age groups. The explanation for this contrast may be that, while the younger patients suffer numerous thromboembolic complications and while some of these complications result in serious damage, the younger patients are able to survive them. Thus an individual under sixty may have three or four thromboembolic complications without a fatal episode whereas an older patient may succumb to the initial attack and hence not have an opportunity of developing repeated thromboembolic attacks. This chart clearly

indicates the value of anticoagulant therapy in preventing thromboembolic complications in all age groups. Within the treated group, a distinction is made between those actually receiving anticoagulants and those who were not receiving anticoagulants at the time of their thromboembolic complications. This further emphasizes the effects of anticoagulant therapy.

The rate of thromboembolic complications by week of illness is considered. The advantage in using anticoagulants is clearly demonstrated for each of the first four weeks of the illness. As is the case with deaths, the incidence of thromboembolic complications is highest in the second week, but is marked throughout the first four weeks. This, again, clearly indicates the importance of beginning anticoagulant therapy even as late as the second or third week following a myocardial infarction. Since it is impossible to predict from the condition of the patient during the first week whether he will develop thromboembolic complications during subsequent weeks and whether he will die from them, it is important to give anticoagulant therapy to all patients with coronary occlusion and myocardial infarction unless specific contraindications exist.

Types and Locations of Thromboembolic Complications

Under the classification of secondary myocardial infarctions, there was evidence of extension of the original thrombosis in nine cases per hundred in the controls as against two cases per hundred in those treated. There was infarction of new areas in the myocardium in 6.5 cases per hundred in the controls as against 2.5 among those treated. Pulmonary emboli occurred in 9.4 cases per hundred among the controls as against 5.2 cases among the treated. Moreover half of the so-called treated cases were not actually receiving anticoagulant therapy at the time they suffered their pulmonary embolus. Cerebral emboli occurred in 3.4 per hundred of the control cases as against 1.4 per hundred among the treated cases. Peripheral emboli developed in three per hundred of the control cases as against one per hundred of the treated and venous thromboses occurred in 5 per hundred of the control cases as against less than two per hundred of the treated. Hence, it will be seen that at every site and with every type of complication, those receiving anticoagulant treatment in addition to conventional therapy had a distinctly better chance of escaping thromboembolic complications than those who received the conventional forms of therapy only.

The hazard of hemorrhagic manifestations resulting from anticoagulant therapy has been carefully reviewed. It should be noted that hemorrhagic manifestations unrelated to anticoagulants numbered six per hundred in the control group. This is in comparison to a rate of slightly more than twelve per hundred cases among those patients who were classified as "odd day" or "treated" patients. It should be noted, however, that of these complications in the latter group, two in twelve developed in patients who were not under anticoagulant therapy when their hemorrhages occurred. In an additional three, the hemorrhages were known to be due to causes other than anticoagulants and not to be aggravated by that therapy. The total hemorrhagic manifestations in the treated group which are known to be due to causes other than anticoagulants approaches that found in the control group. An additional seven per hundred cases, however, were believed to be due to, or aggravated by, anticoagulants. The incidence of severe hemorrhages resulting from anticoagulant therapy was extremely low. Of the thirty such hemorrhages clinically observed, fifteen (50 per cent) were mild in severity, fourteen (47 per cent) were moderately severe, and only one (3 per cent) was severe. The autopsy findings on hemorrhagic phenomena are not yet ready for presentation, but those examined to date present no alarming picture of the hemorrhagic risks in anticoagulant therapy under proper controls. Blumgart and his co-workers,[1] working with dogs whose coronary arteries had been ligated, found that dicumarolized animals (in some instances to prothrombin times of 132 seconds) showed no increase of hemorrhages in the myocardium, endocardium or pericardium as compared with nondicumarolized animals.

Sources of Bleeding in Relation to Anticoagulants

There is a definite incidence of hemorrhages among the control group in each of the categories except that for epistaxis. Hemorrhages due to causes other than anticoagulants also occur in three of the categories in the treated group. There will be noted that hemorrhages occurred more frequently in the treated group in all categories except that of hemoptysis. The explanation for the greater incidence of hemoptysis in control patients is that

pulmonary infarction is much more common among these patients than among the treated cases.

The records of patients who received anticoagulant therapy and yet developed thromboembolic complications or died are being subjected to analysis in the Central Laboratory. It appears, on the basis of present experience, that a considerable proportion of the failures occurred because the prothrombin time was not adequately prolonged. While there is at present a question as to what constitutes the minimal effective therapeutic prothrombin time, it is our experience that a safe and effective therapeutic range is between 30 and 50 seconds by Link-Shapiro modification of Quick's one-stage method. This range, as interpreted in our laboratory, would approximate a prothrombin activity of between 20 and 10 per cent. For heparin, the clotting time should be approximately three times normal. Although statistical evidence as to the relative incidence of thromboembolic complications at various prothrombin times (i.e., at various levels of reduced prothrombin activity) is not yet available, a review of those cases in whom thromboembolic complications occurred during the administration of dicumarol reveals that, of the thirty-eight complications* occurring under these conditions, only four occurred in patients whose prothrombin time is known to have been maintained at levels of 30 seconds or more for at least the three days preceding the appearance of the complication. Further analyses regarding this factor will be recorded in forthcoming publications. It is not sufficient to state that a patient has received anticoagulant therapy. Key questions which must be answered are how much, how long, what levels of effectiveness were obtained, and how consistently were these maintained? With this information it should in the future usually be possible to determine whether a failure was the responsibility of the drug or of those administering it.

Summary

This report summarizes the results obtained by a preliminary statistical analysis of the first 800 cases studied by the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction. In the analysis, the incidence of deaths and of both thromboembolic and hemorrhagic complications has been compared in a "control" series of patients treated by conventional methods alone and in a series of "treated" patients who received anticoagulants (dicumarol, heparin or both) in addition to conventional therapy. The composition of the two groups was found to be essentially the same.

The rates of deaths and the number of thromboembolic complications per hundred cases have been calculated for the control and treated groups as a whole, by week of illness, by age of patient, and by type and location of the specific thromboembolic complication. The percentage of cases developing one or more complications has also been analyzed. The results in every category studied indicate that the use of anticoagulants improves strikingly the outlook of the patient suffering a coronary occlusion with myocardial infarction.

The incidence of hemorrhagic manifestations was also analyzed. It was found that about six minor or moderate hemorrhagic manifestations per hundred cases occur in patients not receiving anticoagulants, but that this incidence is about six per hundred higher in patients receiving anticoagulants. However, only one serious hemorrhage was observed clinically in the entire 800 cases.

Although the minimum prolongation of the prothrombin time necessary to obtain a therapeutic effect from dicumarol in each patient has not been established, it is our experience that a range of from 30 to 50 seconds, as measured by the Link-Shapiro modification of the Quick one-stage technique, produces a safe and an effective therapeutic level. This range of prothrombin times approximates a decrease in prothrombin activity to between 20 and 10 per cent as determined in our laboratory. In using heparin we attempt to prolong the clotting time of whole blood to approximately three times the normal value by the Lee-White technic. In only four cases out of the entire series did thromboembolic complications occur when the prothrombin time had been maintained at a level of 30 seconds or above for at least three days prior to the occurrence of the complication.

Conclusions

1. On the basis of data compiled from 800 cases of coronary occlusion with myocardial infarction, it is concluded that patients treated with anticoagulant therapy in addition to the conventional forms of therapy experience a death rate

(Continued on Page 1351)

*Complications for which the date is not accurately known and those occurring on days for which no prothrombin time is available are excluded from this total, but complications occurring in control cases when under anticoagulant therapy are included.

Medical Diagnosis of Congenital Anomalous Heart

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ALTHOUGH the subject of medical diagnosis of congenital anomalous hearts is listed as in the province of pediatrics, it has become of more than passing interest to almost all branches of medicine. To those of us who had some experience in selecting men for the armed forces, congenital cardiac defects were not rare at all, and by incidence were certainly more than the ½ to 2 per cent found in the general cardiac clinic. We were not always able to make full and exact diagnoses with our diagnostic aids, but a bizarre, harsh, persistent murmur and thrill, usually not at an area of the larger cardiac orifices, often associated with an abnormal roentgen silhouette, were sufficient criteria to screen out this type of cardiac. Until recently this sort of diagnostic status was acceptable, and more exact diagnosis was merely academic. I recall recently at an x-ray conference an excellent roentgenologist stating that, until now, he had been very happy to be able to state that the film apparently was that of a congenital cardiac defect. However, today such generalization is not good medicine. The great reason for this change to more exact diagnosis is the tremendous advance in therapy of congenital defects by plastic operations on the great vessels. In this country the lead in this type of surgery has been taken by Gross, Blalock, Potts and others. But to give this impetus to therapy there have been many helpers, without whose significant researches the surgeon might be lost. The diagnostic team now consists of the pediatrician, internist, physiologist, biochemist, roentgenologist, anesthetist and others.

Fortuitously, or because of it, the three types of defect lending themselves best to surgical relief are diagnosed, most exactly, clinically. According to Maude Abbott's original classification, the *acyanotic group* consists of those without any abnormal communication. Of this group the left-sided stenoses, anomalies of cusps, coarctation of the aorta, congenital hypertrophy, situs inversus, anomalies of the aortic arch or pulmonary vessels are examples. And of this group the condition lending itself well to diagnosis, and recently to surgery, is the so-called adult type of coarctation of the aorta.

The *"cyanose tardive" group* of Maude Abbott consists of those with arteriovenous shunt or late reversal of flow; cyanosis is absent except as an incident to terminal venous arterial shunt or congestive heart failure as in any heart condition. Examples of these are defects in the interauricular, interventricular septa, patent foramen ovale, and patent ductus arteriosus. Of this group patent ductus arteriosus lends itself most readily to diagnosis and actually to surgical cure.

The *cyanotic group* consists of those with permanent venous arterial shunt or right sided valvular lesions, usually with septal defects. In these most grave defects there is persistent cyanosis, clubbing, and polycythemia. Examples are absence of septa or cor bi-loculare or tri-loculare, persistent truncus arteriosus, the so-called tetralogy of Fallot, other valvular atresia with associated septal defect, transposition of the aorta. Again, of these, most of which are difficult to diagnose *in vivo*, the most frequent form and best diagnosed is the tetralogy of Fallot; this too lends itself to the partial surgical cure so notably pioneered by Blalock.

Thus it is clear that it is incumbent on us nowadays to give the surgeon an exact clinical diagnosis. What are the methods and criteria for arriving at the correct conclusion as to the exact congenital defects?

The History.—In this branch of medicine, as in all others, the history is paramount. The knowledge of the presence of a heart murmur since birth is almost pathognomonic of a congenital defect. Exception, however, of this rule can occur as occasionally in the hydrodynamics of the circulation changing at birth from a preponderant right to a left may result in a hiatus of some days or longer before the murmur is heard; also in some defects, notably patent ductus, the murmur changes considerably through the first decade of life. It must also be remembered that functional murmurs are most common; it may be ventured that at some time or other under the stress of infection, anemia, et cetera, all children may have such a so-called transient functional systolic murmur.

The Examination.—If cyanosis is present at birth, congenital cardiac defect is usually the first

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suspicion of the physician. This cyanosis increases on effort, and, if doubtful, making the infant cry or the child exercise makes the cyanosis definite. Clubbing is not present at birth but appears relatively rapidly thereafter, even in a few months, and depends upon the degree of the cyanosis or the severity of the defect. This sign usually becomes apparent first in the thumbs. The concomitant presence of cyanosis and clubbing almost always means a serious congenital cardiac defect. However, too many of us use this as the prime criterion of congenital defect. Actually cyanotic cardiacs are a tiny minority of the congenital defects. Therefore, in our examination we must look for *other* signs. As I mentioned before, an *unusual, persistent murmur* in an *unusual location* is significant. If it it is loud, high-pitched, or harsh, often widely transmitted to distant parts of the body, e.g., the top of the head or along the humeri, mostly basal, and associated with a thrill over the area of maximum intensity, cardiac defect is likely. The point of maximum intensity is important and gives a clue to the site of defect. The phase of the murmur is not so significant, as most murmurs of congenital defect are systolic. Notable exceptions to this are patent ductus and the much rarer pulmonary insufficiency. The blood pressure is helpful in two defects: coarctation and patent ductus.

Laboratory Procedures.—The routine blood count is significant in the blue cardiacs; since this cyanosis is largely due to and a compensating mechanism for the abnormally large number of unoxygenated (red) carriers shunted into the left circulation, the resultant polycythemia is characteristic. It may be severe, 8 to 10 million per cu. cm.; nucleated red cells are absent; the plasma volume may be decreased; the white cells are normal in number and type, as are the platelets. The arterial oxygen saturation is often greatly decreased especially in blue cardiacs. The circulation time may be helpful, e.g., a decreased time suggests an arteriovenous shunt.

Roentgenography, Angiocardiography, Kymography.—In the hands of an experienced roentgenologist, routine x-ray and fluoroscopy give most valuable assistance in diagnosis; in fact, no complete picture of the situation is known without his data, even if his information is negative. Some of the things x-ray will tell us are the degree of pulmonary aeration, the size and pulsatile qualities of the pulmonary artery and its tributaries, the shape of the heart—some defects often having classical configurations, e.g., patent ductus. Secondary rib changes in coarctation may be the first evidence picked up of this condition. Kymography is of very limited aid; however, in patent ductus it gives us gratifying objective evidence of the great decrease in cardiac pulsation especially of the pulmonary conus preoperatively and postoperatively. Angiocardiography with contrast substances requires a more special x-ray setup and much experience, is expensive and of some danger to the patient, and thus is not used frequently except in certain centers.

Electrocardiograph.—This is not so valuable a diagnostic aid as the x-ray. Most defects give no diagnostic electrocardiograph pattern, even though the defect is severe. However, the presence of right or left ventricular preponderance in the electrocardiogram does aid in putting the suspected defect in the group of right or left type of defect respectively; thus, left strain is found in coarctation while right strain is found in tetralogy of Fallot. The presence of heart block or a serious arhythmia, while of importance to the physician, is of small help in pinning down the site of the defect. The only condition pathognomonic by electrocardiograms, the mirror heart of situs inversus, is of no clinical significance except as an oddity.

Venous Catheterization of the Heart.—This procedure, known only about six years, gives promise of considerable aid in the diagnosis of congenital defects which may be aided by surgery. By this method, information as to oxygen saturation and other chemical constituents, intracardiac, intraaortic, intrapulmonary pressures, and films of the catheter in the various chambers and great vessels are obtainable. For example, finding a significantly higher oxygen saturation in pulmonary arterial blood than in right ventricular blood makes the presence of an aortic shunt likely; this information is of vital importance in that fairly large group of patent ductus cases with a noncontinuous murmur. Unexpected and abnormal differences in pressure in the various chambers also are of diagnostic inference. The information from catheterization in the blue cardiac is not so exact and more inferential than in the simpler defects; probably catheterization and visualization with diodrast would be a

more advantageous maneuver in this group. The role of the intracardiac electrocardiograph, feasible through the catheter, is likely more of corroborative than diagnostic information. Its exact role is not yet established.

Clinical Aspects of the More Important Defects

Acyanotic Non-shunt Group: Coarctation of the Aorta.—In this not too rare anomaly, the primary defect is constriction or even atresia of a *localized* area of the aortic isthmus. Usually situated at or quite near the insertion of the ductus arteriosus into the aorta, this situation is probably due to faulty involution of the distal left sixth branchial artery which forms the ductus at its junction with the fourth branchial vessel which becomes the descending aorta. This type, termed the adult form in contradistinction to the infantile, is consistent with viability while the latter is not, as in this there is diffuse stenosis of the *entire* isthmus of the aorta. Immediately after birth in this adult type, as the pulmonary circulation is established the aortic obstruction quickly becomes manifest by rise in pressure in the arteries of the upper part of the body. Soon there may be marked dilatation of the proximal aorta while the thoracic and abdominal aorta continue hypoplastic. When the atresia is high grade, large, even visible, anastomoses between vessels from the lower half of the aorta and the proximal aorta occur; this gives rise to the classical sign of this condition, the paradoxical blood pressure—high in the arms and low or absent in the legs.

There are few or no symptoms of this anomaly in children or even young adults, unless there is marked hypertension or other defects, or unless complications ensue, such as failure, apoplexy, thrombosis or bacterial endocarditis. On the other hand, the *signs* are often sufficient to make the diagnosis readily. A rough systolic murmur at the base, at times even better heard posteriorly in the left scapular area, is frequently present unless the constriction is insignificant. A diastolic murmur is not found unless there is the not infrequent associated patency of the ductus. The heart is often enlarged due to the hypertension, and its shape, as in other types of hypertension, is slipper or bootlike. Pulsating superficial arteries, felt or seen in the back, over the head and anterior trunk at times, point unerringly to an easy diagnosis. The paradoxical blood pressure, often 200 mm. systolic or more in the arms and much lower or absent in the legs, occurs in no other disease. Palpation of the femoral artery and taking of blood pressure in legs of every juvenile hypertensive is mandatory; the physical examination otherwise is glaringly incomplete. Maldevelopment of the lower half of the body, with differences in body temperature between upper and lower, may be found. In older children the roentgenologist may embarrass us by first making the diagnosis, for when present, the roentgen signs are as pathognomonic as the paradoxical blood pressure. These signs are (1) an absent or diminutive aortic knob, due of course to the small aorta distal to the site of the ductus; (2) dilatation of varying degree of the proximal or ascending aorta; (3) left ventricular hypertrophy especially when there is well marked hypertension in the arms; (4) most significant, the so-called notching or scalloping of the ribs. This sign is bilateral often symmetrically and consists of erosion of the inferior margins of some or all of the third to the ninth ribs posteriorly. However, this sign is not present until at least the last part of the first decade and is definite by the fifteenth year of life.

Other noncyanotic non-shunt conditions are often oddities such as situs inversus, simple right aortic arch, and are thus of no diagnostic or clinical significance. Grave conditions such as idiopathic hypertrophy including von Gierke's disease, ectopia cordis, are usually diagnostically obvious but often non-viable. For purposes of this discussion, such rarities as dysphagia lusoria, subaortic stenosis, cusp anomalies, congenital mitral stenosis, pulmonary insufficiency are perhaps not germane.

Cyanosis Tardive Group—Arteriovenous Shunt: Patent Ductus Arteriosus.—This fairly common condition is not truly a defect in development but merely the persistent patency of a major intrauterine vessel, the ductus arteriosus, which connects the pulmonary artery to the aorta but which normally closes physiologicaly a few minutes after birth and by fibrosis rapidly thereafter. Failure to close may be due to inadequate oxygenation of blood because of insufficient aeration and expansion of the lungs immediately after birth. Secondary to perisistent patency there occurs dilatation of the pulmonary artery and its major tributaries, and if the shunt of aortic blood to the pulmonary artery is high grade, there occurs eventually definite enlargement of *both* ventricles.

As a rule there are no symptoms unless failure with cor pulmonale ensues or complications de-

velop, such as bacterial endocarditis. Of all congenital defects in this group, the signs of this condition render diagnosis by physical means not difficult. The classical murmur, when present, as it is in about 80 per cent of cases, is pathognomonic. It is best described as harsh, machinery type, continuous through both phases of the cardiac cycle. However, early in life it is usually systolic in type, but by the seventh year it is biphasic, if it is to become so. It is best heard in the second or third left interspace and left subclavicular area but may be widespread and is most often associated with a thrill of the same phases. The reason for a continuous murmur is that the diastolic arterial pressure is higher than that of the pulmonary system and thus there is a continuous reason for the production of a murmur in both phases of the cardiac cycle. The second pulmonic heart sound is usually heard as accentuated midway in the murmur. In those cases where the murmur is monophasic and the diagnosis becomes essential for possible surgical relief, as mentioned before, intracardiac catheterization may give the diagnosis with fair exactitude; we believe this is the major exception to the dictum: "No biphasic murmur, no operation." The blood pressure is suggestive of the condition when the shunt is considerable and is similar to the Corrigan pulse of aortic insufficiency, i.e., high pulse pressure, the systolic however not usually elevated, capillary pulse and pistol shot in the femoral. The x-ray is of considerable aid, although when the ductus is small the heart size and shape are normal; when the ductus is large the film and fluoroscopy are characteristic. There is marked prominence at and above the site of the pulmonary artery, at times termed the "ductus cap." Fluoroscopy reveals the so-called "hilar dance" which is due to the pulsating large pulmonary vessels at the lung hila. The electrocardiogram often shows left ventricular preponderance. Conditions which may need differentiating from patent ductus are interauricular septal defect and aortic septal defect; the type and location of the murmur, the peripheral signs, and the x-ray will often be sufficient; intracardiac catheterization will aid in these doubtful cases. Interventricular septal defect usually is not confused with patent ductus as the typical harsh systolic murmur and thrill of Roger at the third and fourth left interspace occurs practically in no other condition.

Cyanotic Group: Venous Arterial Shunt—Tetralogy of Fallot.—In approaching the diagnosis of this condition, a simple rule is of great aid, i.e., "all congenitally blue cardiacs are tetralogies until proven otherwise," as from three-fourths to nine-tenths of all such cases are pathologically of this type. The primary defect of the tetrad is failure of development of the conus arteriosus; this gives rise to (1) pulmonary or infundibular stenosis or atresia, (2) patent interventricular septum, high in the membranous portion, (3) overriding of the aorta at the site of the patent septum, i.e., detroposition of the aorta, and (4) compensatory right ventricular hypertrophy.

There usually are symptoms in this condition. Dyspnea is often present, the child often assuming a squatting position after light exercise in attempting to catch his breath. Cough is frequent, weakness, maldevelopment and complications such as thromboses, pulmonary hemorrhage, convulsions are not infrequent. The physical examination shows the characteristic clubbing and cyanosis already mentioned. In the pulmonic area, systolic murmur and thrill are usually present, the intensity being in proportion to the cyanosis rather than the degree of pulmonic stenosis, for if the stenosis is high grade no murmur may be heard. As compensation for the pulmonary deoxygenation and because of the overworked respiratory system, there may develop kyphosis and spinal deformity. The x-ray findings are usually characteristic; the apex is high, at times appearing as a double tip, and is of course due to the right ventricular hypertrophy, but there may be no over-all enlargement of the silhouette. The area of the conus is concave or scaphoid in all cases. In the anterior oblique view, Helen Taussig pointed out that the pulmonary window is unusually clear, the pulmonary markings at the hila are minimal and the lungs unusually clear. Fluoroscopy shows the dextroposed aorta and the absence of hilar pulsations. About one-fourth of the cases show a right aortic arch on fluoroscopy with barium. The typical polycythemia has already been mentioned, as well as the suggestive electrocardiogram with right ventricular preponderance, extreme voltage and huge P waves.

The only blue cardiac necessary to be differentiated is that wastebasket diagnosis, the Eisenmenger complex, in which insufficiency of the pulmonary vessel rather than stenosis is supposed to oc-

cur. In this a diastolic murmur may be heard. The x-ray shows a globular heart, no concave conus, no clear window, but pulsating hila. It is obvious that in this type of lesion a shunt into the pulmonary system already physiologically exists, and another made artificially will not be indicated. The various types of transposition of the great vessels, common truncus and cor triloculare are not readily diagnosed *in vivo* and are probably not suitable for discussion in this brief paper, although perhaps ameliorated by surgery.

Conclusion

In conclusion, I might state that this résumé of the problems of diagnosis is of course very incomplete. I have been forced to omit discussion of all defects but those lending themselves to modern surgical relief and/or cure. However, it is encumbent for us to make these diagnoses exactly and early in life to give our patients their best chance. With the rapidly advancing strides in chest surgery and the newer safer methods used by our anesthesiologists, the prognosis for these cardiacs is immeasurably improved.

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REPORT OF COMMITTEE, AMERICAN HEART ASSOCIATION

(Continued from Page 1346)

and incidence of thromboembolic complications during the first six weeks period following an attack markedly lower than those experienced by patients treated solely by conventional methods.

2. Anticoagulant therapy should be used in all cases of coronary thrombosis with myocardial infarction unless a definite contraindication exists.

3. In the absence of hemorrhagic conditions the hazards from hemorrhage are not sufficient to contraindicate the use of anticoagulants in coronary occlusion providing there are facilities for adequate laboratory and clinical control.

References

1. Blumgart, H. L., Freedberg, A. S., Zoll, P. M., Lewis, H. D. and Wessler, S: The effect of dicumarol on the heart in experimental acute coronary occlusion. Tr. A. Amer. Physicians, 60:228, 1947.
2. Nichol, E. S. and Page, S. W. Jr.: Dicumarol therapy in acute coronary thrombosis: Results in fifty attacks. J. Florida M. A., 32:365, 1946.
3. Peters, H. R., Guyther, J. R. and Brambel, C. E.: Dicumarol in acute coronary thrombosis. J.A.M.A., 130:398, 1946.
4. Solandt, D. Y. and Best, C. H.: Heparin and coronary thrombosis in experimental animals. Lancet, 2:130,1938.
5. Solandt, D. Y., Nassim, R. and Best, C. H.: Production and prevention of cardiac mural thrombosis in dogs. Lancet, 2:592, 1939.
6. Wright, I. S.: Experiences with dicumarol in the treatment of coronary thrombosis. Proc. Am. Fed. Clin. Research, 2: (Dec. 28-29) 1945.
7. Wright, I. S.: Experiences with dicumarol (3,3' methylenebis (4-hydroxycoumarin) in the treatment of coronary thrombosis with myocardial infarction. Am. Heart J., 32:20, 1946.

Large Pancreatic Cyst

Case Report, General Discussion and Review of the Literature

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AN INTRAABDOMINAL tumor, large enough to be seen or palpated with ease by the examining physician, has always been an interesting diagnostic problem, particularly when there is little or no complaint leading up to its discovery. With this thought in mind, a case history revealing a rapidly growing pancreatic cyst which attained great size in a young woman is added to the literature of reported pancreatic abnormalities. Although a presumptive diagnosis of cyst of the pancreas was made prior to operation, the differential diagnosis included hepatic, mesenteric, omental or splenic cyst; hydrops of the gall bladder; retroperitoneal neoplasm; hydronephrosis; and more remotely, aneurysm and ovarian cyst.

C.Y.K., white female nurse (student), age twenty, was admitted to Community Hospital March 12, 1946, complaining of a fullness of the upper abdomen, a visible swelling which was growing in size. This was discovered on examination for entrance to training March 8, 1946. She first noted this fullness in October, 1945, but had only recently noticed some pain in her back and abdomen on exertion.

Personal history revealed a good appetite, no complaints of indigestion, constipation or diarrhea. Her temperature was 99 degrees F., pulse 80 per minute, weight 163 pounds. Blood pressure was 112/80. In the left upper abdomen there was a soft, cystic mass visible with the patient supine, exaggerated in size on standing. This filled the left upper quadrant, was 18 to 20 centimeters in diameter, could be moved very little. Fixation seemed deep in the abdomen, and a firmer portion of the mass was felt on deep palpation, eliciting tenderness.

Catheterized urine showed no albumin, sugar or bile, and contained 1 to 2 WBC/HPF. Hemoglobin was 88 per cent, white blood count 9,500, and red blood count 4,100,000. Serum amylase showed 143 milligrams of amylolytic activity (normal 30 to 100 milligrams). Gastrointestinal x-rays (Fig. 1) revealed marked displacement of the stomach downward and to the right. The cecum was dilated, low and the splenic flexure was displaced downward. The left diaphragm was elevated. Because of incomplete visualization of the left kidney

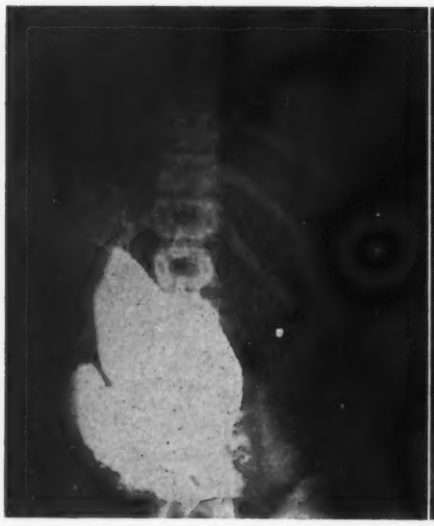

Fig. 1.

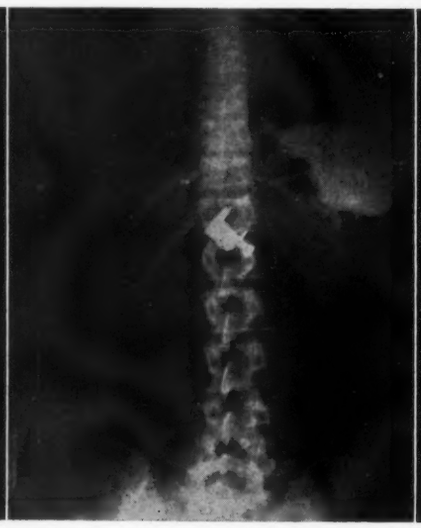

Fig. 2.

Fig. 3.

by intravenous pyelograms, cystoscopy and retrograde pyelograms were done and were negative.

Laparotomy was done March 26, and a tense thin-walled cyst appeared as the peritoneum was opened. This seemed to arise from the liver, the thickest portion of its wall having a reddish cast like hepatic tissue and was so thin anteriorly that one area seemed ready to rupture. Trochar aspiration produced more than 5 liters of straw-colored fluid, with fatty globules (additional fluid escaped into large abdominal packs plus a small amount left in the cyst). Exploration showed the cyst arising above the head of the pancreas in a long stalk which crossed the lesser curvature of the stomach through the gastrohepatic ligament. The pancreas was normal in size and consistency. The cyst adhered to the upper edge of the spleen, was freed, marsupialized and packed. Postoperative diagnosis was pancreatic cyst. A piece of the cyst removed for microscopic study showed a fibrous wall with dense lymphocytic infiltration, granulation tissue with areas of cuboidal or ovoid cells forming a lining and many cholesterin crystals. Tests for trypsin and bile were negative. Pathological diagnosis was pancreatic cyst. The packs were removed under anesthesia on the ninth postoperative day, releasing over a pint of dark brown fluid, and were replaced by two soft rubber tubes. A drop in blood total proteins to 5.4 grams was corrected by oral protein therapy.

On the twenty-sixth day after operation the cystic cavity held 5 ounces of normal saline, and five days later 50 per cent Skiodan was injected (held 200 cubic centimeters) for x-ray study (Figs. 2 and 3). The opaque shadow measured 4 inches and extended backward into the retroperitoneal space under the left lobe of the liver. Drainage from the sinus was only moderate, and the wound healed rapidly around the tubes. Skiodan injection was repeated eight weeks after operation, the cavity holding three ounces (Fig. 4); again twelve weeks postoperatively (Fig. 5) at which time only 1 ounce was retained, and sixteen weeks after operation (Fig 6) when no Skiodan was retained, and report was given that "the sinus has entirely closed." Two cubic centimeters of sclerosing solution (Etalate) were injected into the sinus June 23 without any untoward reaction. This was repeated July 1 and again on July 16. On August 27 the sinus was only one-half inch deep and healed rapidly in a few weeks.

Check-up examination was done November 29 and showed excellent healing, a strong scar and no subjective complaints. Final examination May 3, 1947, more than a year after operation, found the patient in excellent physical condition, complaining only of a mild pulling sensation in the upper abdomen which followed exercise. There was slight dimpling at the site of drainage in the scar. Physical examination and laboratory studies showed no abnormality. She was leading a normally active life. An attempt to obtain a report by letter November, 1947, was unsuccessful; the patient could not be traced.

Cyst probably was the first disease of the pancreas to be treated surgically[27] for Morgagni[38] described multiple cysts on the pancreas in a cadaver in 1761, and Claessen[12] reviewed a series of cases from the literature in 1842.

Frequency

Reports from surgical clinics and teaching hospitals attest to the infrequent occurrence of all types of pancreatic cysts. White[56] found only three cases in 6,708 autopsies done at Guy's Hospital, London. Only nine cases were observed at the Lahey Clinic[1] from its origin in 1926 to October 1, 1945. Seven cases of cyst were found among 158 surgical lesions of the pancreas at Johns Hopkins Hospital[47] from 1889 to 1932. Judd[27] reported forty-one cases in 1921, the largest original series up to that time, and later[28] an additional forty-seven cases or a total of eighty-eight pancreatic cysts from 723,397 patient admissions to the Mayo

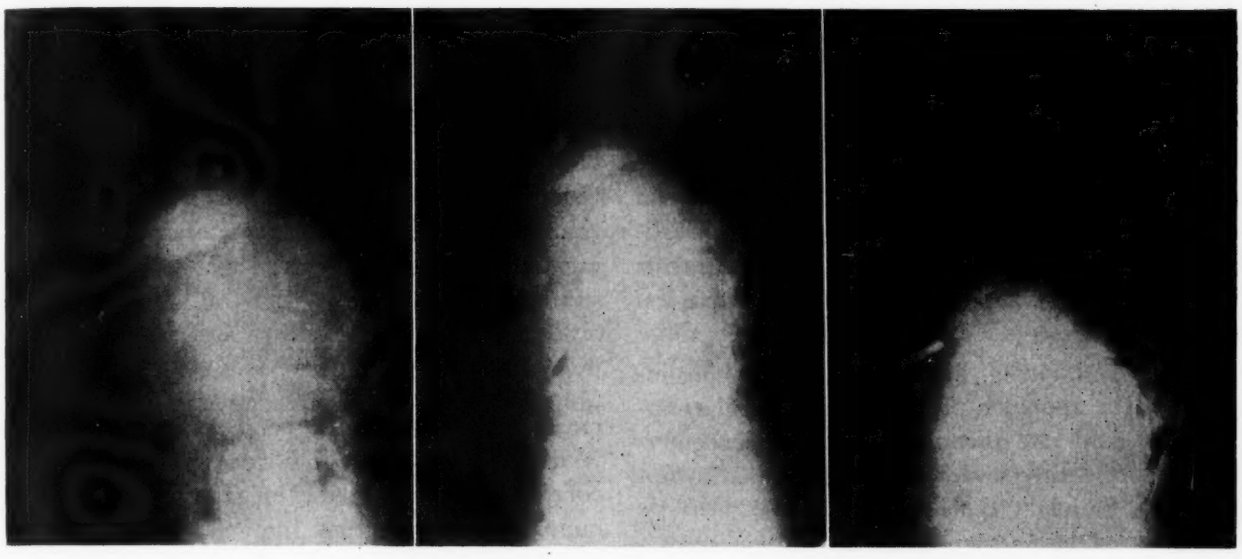

Fig. 4. Fig. 5. Fig. 6.

Clinic. In 1941[54] this same group reported fifty-one more cases to record the largest series published by any one clinic. Six cysts[26] were reported from twenty-one pancreatic cases at Hurtl's Clinic 1923 to 1936, and a questionnaire directed to over 100 European clinics[49] culled 2,137 cases of acute pancreatic necrosis from their records with only 128 cases of cyst. Only five pancreatic cysts were found in the surgical records of Massachusetts General Hospital[57] from 1920 to 1937.

Incidence

This is a disease of middle life, occuring most often in individuals between the ages of twenty and forty years. There are a few reports of true pancreatic cysts in infants, among them[18] a congenital cyst in a female, five months old, which was successfully removed from the tail of the pancreas. Although some of the recent reports find the two sexes affected with equal frequency, the literature favors a moderate predominance in females.

Classification

Thigpen's[53] etiologic classification of pancreatic cysts, derived from an extensive review of the literature has been published by Walters and Cleveland[54] as follows:

1. Pseudocyst, a cyst without an epithelial lining, the result of trauma to or inflammation of the pancreas.
2. Retention Cyst, which results from obstruction to the outflow of secretion by calculi or by pancreatitis.
3. Neoplastic Cyst including cystadenoma, cystadenocarcinoma, sarcoma, teratoma.
4. Cyst Resulting from Defective Development.
5. Parasitic Cyst, such as the hydatid variety.

The rare dermoid cyst[27] might be added to this as a separate classification. Only three such cases[16] have been reported.

Retention cysts are the most common type and are rarely large, occurring in the head or body of the pancreas. Parasitic cysts are infrequent.

Cysts from defective development are of varied nature, some similar to the congenital cysts of the kidney and liver. They may arise from misplaced remnants of Brunner's glands[46]. Hemangiomas of the pancreas are included in this group.

Neoplastic cysts are rare, comprising only four and one-half per cent or two of 108 cases from the Mayo Clinic. There were two in the nine cases of cyst reported from the Lahey Clinic. Individual case reports[4,5,6,8,9,29,41,57] are infrequent and Jemerin[24] very recently published the twenty-ninth case of cystadenoma recorded in the literature. A malignant polycystic tumor similar to those in Lindau's disease[36] and a 7-liter cyst with cells of Langerhans "like fibroplastic sarcoma"[38] are among the less common types.

Pinkham[44] has published an excellent discussion of the etiology of pancreatic pseudocysts and collections, listing trauma, acute and chronic pancreatitis and hemorrhagic necrosis of this organ as leading causes. Degenerative changes within the gland lead to cyst formation within the pancreas, while the corrosive action of pancreatic ferments released into the lesser peritoneal sac produce encapsulated collections about the gland. In either type the surgeon will usually find the cyst in one

of three locations, between the stomach and the transverse colon under the gastrocolic omentum; between the stomach and the liver, under the gastrohepatic omentum; or between the layers of the transverse mesocolon. Dense connective tissue forms the wall of a pseudocyst, and it may be lined by endothelium. The true cyst is lined by epithelium, which if destroyed by pancreatic ferments makes its differentiation from the pseudocyst impossible.

Varied accounts of minor to severe crushing injuries of the abdomen producing few initial symptoms and moderate discomfort, up to surgical emergencies presenting severe acute abdominal symptoms are found in the literature[2,15,17,21,22,25,33,34,37,42,49,50] and lately there have been some reports of acute trauma to the pancreas from war injuries.[32] Selecting figures given by seven different writers, the number of cysts resulting from trauma varies from 12 per cent (von Schmieden) to 33 per cent (Heiberg), averaging 20 per cent.

Held[23] distinguishes pseudocyst as forming shortly after trauma and true cyst as occurring long after the initial injury. Hemorrhage of and trauma to the pancreas form the basis for the development of cyst. Some cysts following known trauma represent hematomas of the lesser omental bursa, while others have clear, cloudy or deeply colored fluid according to the action of the ferments released.

The role of acute and chronic pancreatitis[1,10,14,28,44,52] as an etiologic factor in the production of true and false cysts has received increasing emphasis lately. The mechanism involved is problematic, although most observers feel that fibrosis of the gland constricts the pancreatic ducts producing obstruction and dilatation beyond the area blocked. Chronic cholecystitis and other types of biliary tract disease,[6,10,14,28,37,44] common bile duct obstruction, and portal vein obstruction are commonly associated with pancreatic cysts and must be included in the list of important causative factors. Although hemorrhagic necrosis of the pancreas may damage the gland more extensively than trauma, pseudocyst formation follows in much the same sequence as it does from trauma, and the cysts are alike.[28,37,44,49]

The pseudocyst is usually unilocular, varying from five to 35 centimeters in diameter. Large cysts are unusual and may require heroic surgery for their removal. They may contain four liters of fluid[1,21,35,44] 5 liters,[40,45] 6 liters,[35] 7 liters[38] and rarely 20 liters.[23,35] Since it is rarely possible to distinguish between hematogenic collections, pseudocysts and pancreatic suppurations at operation or at autopsy, it has been suggested[35,44] that the terms "false" or "pseudocysts" be discarded. Instead, the term pancreatic cyst or collection resulting from trauma, duct obstruction, acute and chronic pancreatitis, or pancreatic necrosis should be substituted.

Symptoms

Pain is the most constant symptom of pancreatic cyst, found in 85 per cent of patients and is described as dull and steady, or severe and colicky, occurring in the epigastrium, left upper quadrant, or radiating into the back. Nausea, vomiting, weakness, weight loss and even jaundice are later symptoms. Mild persistent flatulence, sense of pressure and anorexia are often present.

Signs

A palpable mass in the upper abdomen, usually the left upper quadrant, is the most constant sign. Several cases of pancreatic cyst accompanying pregnancy which sometimes complicated the diagnosis[35,43,45] are recorded. One cyst containing five liters of fluid was found following delivery.

X-ray plays an important rôle in the diagnosis, the stomach and bowel being moderately or considerably displaced, and the duodenal loop may show considerable widening. A flat plate of the abdomen may reveal the outline of a cyst. Cholecystogram[7] may show a distended gall bladder whose opaque shadow persists much longer than usual (several days instead of thirty to sixty minutes) due to obstruction to the escape of bile, and in late stages the gall-bladder shadow is no longer seen. Gastric pneumograms have been done in some clinics with success, using the posterior wall of the distended stomach to outline the pancreas.

Laboratory studies may not be very helpful, but often a blood serum amylase well above normal can be demonstrated to substantiate the diagnosis of pancreatic cyst. Trypsin, when present in the fluid obtained from a cyst identifies its pancreatic origin. Diabetes has been reported in five to eight per cent of these cases[44] and Bowers[6] found diabetes in three of five cases presented.

Complications

Rupture of a distended pancreatic cyst into the abdomen or into some hollow viscus[29,34] is a rare complication which should be considered in the

differential diagnosis of acute abdominal conditions. Accompanied by considerable shock and evidence of peritonitis, the mortality from this accident in the largest series of cases reported was 66 per cent. Sudden hemorrhage into a cyst may simulate an abdominal emergency, is usually diagnosed as peritonitis preoperatively[25,41,44] and may cause collapse of the patient. At operation the abdomen may be filled with blood. Obstruction of adjacent organs by direct pressure of a large cyst or an adherent cyst is a late complication, resulting in symptoms of intestinal obstruction, vomiting, or diarrhea.

Treatment

Total excision is now the treatment of choice [1,3,10,15,28] in all but the very large pancreatic cysts, or adherent growths which defy surgical removal, and is the particular treatment of cystadenoma and other malignant types.[4,5,8,9,13,15,24,36] The cyst is often incised at its base and enucleated, and at times partial pancreatectomy[48] may be required for complete removal. Proponents of total excision score the long draining sinus (eight months up to fifteen years) which may follow marsupialization and drainage,[20,28,30,33] a fistula which may lead to death from retroperitoneal sepsis and thrombophlebitis of the inferior vena cava.

Anastomosis of a pancreatic cyst to an adjacent hollow viscus, the duodenum, jejunum, gall bladder or stomach has gained favor recently[1,26,31,32,40,51] and is an excellent cure for the chronic fistulous tract which sometimes follows marsupialization.[3,11,13] This may be done for the adherent cyst and for the cyst with large vessels in its wall.[6]

Marsupialization and drainage has been a satisfactory and final type of treatment for benign cysts in the experience of most surgeons.[13,37,55] The time limit for automatic closure of a postoperative fistula is about nine months, after which measures for its exclusion are indicated. Silver nitrate irrigations[17] have accelerated the obliteration of a sinus, while some report good success with the use of sclerosing solutions such as sodium morrhate.[19] Tincture of iodine has been used to destroy the lining of a cyst. Direct introduction of radium into the sinus and x-ray therapy[20] over it, or a combination of both have been used with success.

Summary

Although published clinical records of pancreatic cyst are increasing in the medical literature, the condition remains a rare occurrence in the experience of most surgeons. From individual reports as well as those from large hospitals and clinics it appears that any one surgeon may encounter one or two pancreatic cysts in his lifetime. Many will never have this experience.

This case was considered worth discussion because of the considerable size of the cyst; its rapid growth with few accompanying symptoms (only mild discomfort); the serial x-ray studies taken before and after surgery demonstrating rapid decrease in its size; the absence of any obvious etiologic factor in its production; the complete obliteration of its sinus with the aid of a sclerosing solution; and the successful clinical result without residual effects. In this review, the current literature on pancreatic cyst has been brought up to date.

Bibliography

1. Adams, Ralph and Nishijima, R.: Surg. Gynec. & Obst., 83: 181, 1946.
2. Aldis, A. S.: Brit. J. Surg., 33:323, 1946.
3. Aubert, V.: J. de Chir., 48:892, 1936.
4. Beloff, J. S.: J. Mt. Sinai Hosp., 12:817, 1945.
5. Benson, R. E. and Gordon, W.: Surgery, 21:353, 1947.
6. Bowers, R. F., Lord, J. W., and McSwain, B.: Arch. Surg., 45:111, 1942.
7. Borak, J.: Wien. klin. Wchnschr., 48:399, 1935.
8. Carling, E. R. and Braxton, J. A.: Brit. J. Surg., 13:238, 1925.
9. Carter, R. F. and Slattery, L.: Am. J. Digest. Dis & Nutrition, 3:705, 1936.
10. Carter, R. F., and Slattery, L. S.: S. Clin. North America, p. 411, (April) 1947.
11. Chapman, C. L. G.: Brit. J. Surg., 28:633, 1941.
12. Claessen, H. J.: Die Krankheiten der Bauchspeichdeldruse by Kohn, M. DuMont-Schauberg, page 368, 1842.
13. Cole, Warren H.: S. Clin. North America, p. 16, (Feb.) 1944.
14. Comfort, M. W., Gambill, E. E., and Baggenstross, A. H.: Gastroenterol., 6:376, 1946.
15. Connolly, Earl A. and Lempka, A. W.: Am. J. Surg., 74:805, 1947.
16. DeCourcy, J. L.: Ann. Surg., 118:394, 1943.
17. Drennen, E.: Ann. Surg., 76:488, 1922.
18. Eha, C. E.: J.A.M.A., 78:1294, 1922.
19. Gordon, A. E.: Ann. Surg., 106:1095, 1937.
20. Hamilton, C. S.: Surg. Gynec. & Obst., 35:655, 1922.
21. Harrison, C. and Cooper, F.: J. Tennessee M. A., 36:299, 1943.
22. Heiberg, R. A.: Krankheiten der Pankreas. Wiesbaden, 1914.
23. Held, I. W.: M. Clin. North America, 24:855, 1940.
24. Jemerin, E. E. and Samuels, Norman A.: Ann. Surg., 127:159, 1948.
25. Jones, Eli S.: J. Indiana M. A., 37:175, 1944.
26. Josa, L.: Zentralbl. f. Chir., 63:1708, 1936.
27. Judd, E. S.: Minnesota Med., 4:75, 1921.
28. Judd, E. S., Hamlin Mattson and Mahorner, H. R.: Arch. Surg., 22:835, 1931.
29. Kennard, H. E.: Surgery, 9:65, 1941.
30. Kerr, A. A.: Surg. Gynec & Obst., 27:40, 1918.
31. Kerschner, F.: Zentralbl. f. Chir., 62:1089, 1935.
32. Keynes, G.: Brit. J. Surg., 32:300, 1944.
33. Korte: System of Practical Surgery. By von Bergman, Bruns and von Mikulicz. Vol. IV, page 726. Transl. by Wm. T. Ball, et al, Philadelphia: Lea Bros., 1904.
34. Koucky, John D. Surg. Gynec. & Obst., 73:113, 1941.
35. Mahorner, H. R. and Mattson, H.: Arch. Surg., 22:1018, 1931.
36. McKechnie, Robert E. and Priestly, J. T.: Canad. M. A. J., 36:592, 1937.
37. McWhorter, G. L.: Arch. Surg., 11:619, 1925.
38. Meyer-May, J.: Mém. Acad. de chir., 63:562, 1937.
39. Morgagni, G. B.: The Seats and Causes of Diseases. Vol. 5, page 578. London, 1909.
40. New England J. Med., 237:194, (Aug. 7) 1947.
41. New England J. Med., 224:1112, (June 26) 1941.

(Continued on Page 1379)

Cervical Sympathetic and Stellate Ganglion Block in Apoplexy

Preliminary Note on Indications and Technique

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THE RATIONALE for interrupting sympathetic impulses to the region of the brain involved in a vascular accident has only recently become partially accepted.

In the past, it was widely held that the cerebral circulation was very little altered by emotional stress, and that the vasomotor nerves in the brain were weak in comparison to vasomotor impulses elsewhere in the body. The role of the carotid sinus and aortic depressor mechanisms in maintaining a constant tonus of cerebral vessels was emphasized by Soma Weiss[8] in 1938.

However, Villaret and Cachera[6] in Paris demonstrated in animal experiments, utilizing a window in the skull, that after occlusion of a cerebral (pial) vessel, reflex vasospasm, and diapedesis of red cells following venostasis in the area about the occlusion occurred. These phenomenon, which could be abolished by blocking cervical sympathetic nerves, were similar to those observed in vascular occlusion elsewhere in the body, and demonstrate in retrospect that the principles applying to vascular disease in general, likewise, hold in vascular disease involving the central nervous system.

Stellate ganglion block for hemiplegia was first performed by Leriche and Fontaine.[4] In two cases of postoperative hemiplegia, they infiltrated the stellate ganglion of the affected side with a marked regression of symptoms. They believed that the block released vasoconstriction about the lesion (ischemic or hemorrhagic) with resultant diminution of edema. Mackey and Scott[5] obtained good results in nine patients in a series of nineteen cases of acute cerebrovascular accident treated with cervical sympathetic block.

Their criterion for success was rapid improvement of symptoms because it is well known that in some cases of apoplexy, spontaneous improvement may occur within the first few hours. They found that cases of cerebral embolism in young patients responded most dramatically of any type of apoplexy. Good results were obtained in cerebral thrombosis and poor results were obtained in cases of cerebral hemorrhage. Volpitto and Risteen[7] in this country confirmed the poor results in cases of cerebral hemorrhage and reported encouraging results in cerebral thrombosis when stellate ganglion blocks were employed.

In March, 1948, de Takats and Gilbert[2] created great interest in this procedure by reporting dramatic improvement in nineteen of twenty-five patients with early apoplexy treated with cervical sympathetic block. Their report heralds a new era of active treatment for a condition in which previously, by and large, treatment has been considered pretty hopeless by the medical profession. These investigators again stressed the importance of differentiating between cerebral embolism, thrombosis (or softening) and hemorrhage. Apoplexy due to hemorrhage was not treated with cervical sympathetic block. This type of apoplexy is highly fatal, and the mortality resulting from it is 77 per cent at St. Luke's Hospital, Chicago. In properly selected cases (acute apoplexy due to embolism or thrombosis), regain of consciousness and of speech, motor improvement and conversion of flaccid into spastic paralysis were observed. In order to credit the improvement to the sympathetic block, regression of symptoms must occur within ten to twenty minutes following the block.

Indications for Cervical Sympathetic Block

As the purpose of this report is to bring this procedure to the attention of the physicians in this state and to further encourage a more active treatment of apoplexy, the indications and technique in use at our clinic since April 1, 1948, will be outlined. As our series of cases is still too small to be significant, an analysis of results must await further experience.

Patients with acute apoplexy or with residual symptoms resulting from old cerebral vascular accident are admitted on the medical service either to the hospital as bed-patients, or to the clinic as

Presented at the meeting of the Staff of the Alexander Blain Hospital and Clinic on June 2, 1948.
From the Department of Surgery, Alexander Blain Hospital, Detroit, Michigan.

out-patients, depending upon the seriousness of their disease.

In the case of patients with acute apoplexy, lumbar puncture is performed immediately after admission. If the spinal fluid is bloody and under increased pressure, the diagnosis is assumed to be cerebral hemorrhage. Sudden onset of symptoms, markedly elevated blood pressure, increased white cell count, stiff neck and deepening coma are further signs of hemorrhage. In this type of patient, cervical sympathetic or stellate ganglion block has not yet been employed.

If the spinal fluid is clear with elevated pressure, if the coma is not deep and not progressive and the hypertension moderate, the presumptive diagnosis is cerebral thrombosis and the patient is referred to the surgical department for cervical sympathetic block. It should be stated that cerebral embolism must be ruled out before making a diagnosis of cerebral thrombosis, although the immediate treatment insofar as sympathetic block is concerned, is the same. In general, embolism is diagnosed when the patient has an obvious cardiac lesion, either rheumatic (usually with fibrillation) or due to a myocardial infarct. These patients have clear spinal fluid without an elevated pressure and are often of younger age.

In patients with chronic sequelae of old vascular accidents, the differential diagnosis from the standpoint of using sympathetic block is not so important because one is attempting to treat the late circulatory disturbances produced by cerebral infarction which may continue to play a role in the pathogenesis of sequelae such as hemiplegia, dysarthria, and causalgia. We have recently seen a patient with hypertension who had a small vascular accident (presumably thrombosis) which interfered with the blood supply of the left eighth nerve. This accident was heralded by the sudden onset of left complete eighth nerve deafness and Ménière's syndrome (tinnitus, headache, nausea, vomiting, and dizziness) indicating that both acoustic and vestibular branches of the eighth nerve were involved.

As would be expected, the results of sympathetic block in the cases of long duration are not at all as dramatic as in acute cases. The present writer has performed some twelve blocks, either of the cervical sympathetic chain or stellate ganglion, on ten cases of long duration in the course of perfecting the technique of the procedures. In about half of these, no benefit of any degree was observed. It is of interest that in the first patient in which cervical sympathetic block was performed three months ago a year after an attack of cerebral thrombosis, incapacitating dysarthria was completely relieved for twenty-four hours, and causalgic occipital headaches have been relieved up to the present writing. This patient had almost no residual hemiplegia so that no evaluation of the effect of the block on this sequela was possible.

In an acute case of cerebral thrombosis, coma and hemiplegia were dramatically relieved within five minutes after production of a Horner's syndrome. The symptoms returned, and a second block the following day was much less beneficial. The patient, a fifty-year-old man from Dexter, Michigan, was scheduled for a bilateral supradiaphragmatic sympathectomy, and splanchnicectomy for malignant hypertension, but died the night before the operation.

Technique

The technique of cervical sympathetic block can be mastered by any physician, whether surgeon, internist or general practitioner, if certain precautions, to be discussed, are kept in mind. Stellate ganglion block is a dangerous procedure except in the hands of a surgeon versed in the procedure and employing it only in a well-equipped hospital. This danger is due to the fact that the stellate ganglion is located behind the uppermost portion of the dome of the pleura and the needle can puncture the pleura producing pneumothorax and even massive collapse of the lung. For the occasional operator, cervical sympathetic block is safer, easier, and just as effective therapeutically in the treatment of apoplexy.

Cervical sympathetic block is done either in the operating room, if the patient can be conveniently and safely moved, or with the patient in his bed. As with all procaine injections, 2 mg. of sodium phenobarbital or other barbiturate are given preoperatively to lessen the risk of a procaine reaction.

The patient lies on his back with his neck hyperextended. A pillow is placed under the shoulder of the side of injection (the side of the central lesion), and the head is turned away from the site of the injection. If the posterior border of the sternocleidomastoid muscle is not prominent, the patient is asked to raise his head against the pressure of the operator's hand. This border is

located prior to palpation of the transverse processes of the cervical vertebrae. The site of injection, posterior to the sternomastoid border above the clavicle and over the transverse process of the sixth cervical vertebra, is painted with merthiolate, and the rest of the neck is draped. A dermal wheal is placed with a 1 per cent solution of procaine hydrochloride (without epinephrine) over the tip of the sixth transverse process. A lumbar puncture needle with stylet is inserted through the wheal until it makes contact with the tip of the transverse process. The needle slides anteriorly and medially until the point lodges in the groove at the juncture of the transverse process and the body of the vertebra. When the needle point is in contact with the vertebral body, aspiration is done for blood, spinal fluid, and air. If none of these is observed, 15 to 20 c.c. of a 1 per cent solution of procaine hydrochloride are injected slowly with occasional aspirations during the procedure. While we have not yet used proctocaine or other longer-acting preparations, we are contemplating their substitution for procaine in the near future.

The stellate ganglion is blocked anteriorly by placing the needle lower and sliding its point down over the anterior surface of the transverse process of the seventh cervical vertebra. The needle is inserted at an angle so that its point will be medial to the dome of the pleura. The techniques of Leriche and Fontaine[3] and of de Bakey and Ochsner[1] should be studied prior to attempting stellate ganglion block which is, as stated, unsafe in unskilled hands.

All successful blocks are followed within five to ten minutes by a Horner's syndrome of the affected side; this is characterized by myosis, drooping upper eyelid, dryness and warmth of the affected side of the face and dilatation of the conjunctival vessels.

A failure to obtain a Horner's syndrome warrants a repeat of the block as it indicates that the first block was unsuccessful. In early cases of apoplexy having quadriplegia, bilateral blocks in two stages are recommended. It is altogether possible that bilateral sympathetic blocks will prove with further experience to be superior in all cases of apoplexy. At present, our experience is limited mostly to unilateral block on the side of the lesion. In general, if a successful block followed by a Horner's syndrome has not resulted in clinical improvement, we have not repeated it. The successful block is repeated only if encouraging relief of symptoms has been obtained.

Summary

It can readily be seen that the clinical evidence favoring the value of cervical sympathetic and stellate ganglion block in apoplexy is much stronger than experimental evidence, yet the studies of Villaret and Cachera alluded to offer convincing proof that cervical sympathetic block relieves vasospasm, diapedesis and transudation in the zone of cerebral tissue surrounding a vascular occlusion.

All students of this procedure are agreed that cases of cerebral hemorrhage should be eliminated before a block is carried out for apoplexy. However, the final judgment in this connection has not yet been made.

The technique of cervical sympathetic block can be learned by the physician in general practice, in a small community, or elsewhere, and can be done safely if certain precautions discussed are remembered. It appears that definite therapeutic help may be rendered to properly selected patients. The technique for stellate ganglion block by the anterior approach is dangerous and is recommended only for those properly versed in this procedure, employing it in well-equipped hospitals. A discussion of stellate ganglion block by the posterior approach for the treatment of angina pectoris or of causalgia of the upper extremities is not within the scope of this communication. While general measures in the treatment of acute apoplexy, such as oxygen administration, catheterization of the urinary bladder and so on, have not been discussed, these, of course, cannot be neglected.

The management of apoplexy at this hospital has been outlined with regard to the use of cervical sympathetic and stellate ganglion block. Some preliminary impressions regarding the efficacy of these procedures have been mentioned.

AUTHOR'S NOTE: I am indebted to Dr. Geza de Takats of Chicago for helpful criticism during the preparation of this report. He has pointed out that chronic invalids should not be given false hope that such procedures will alleviate their invalidism except in some cases of thalamic pain, causalgia, and so on.

References

1. De Bakey, M., and Ochsner, A.: Treatment of thrombophlebitis by novocain block of sympathetics: technique of injection. Surgery, 5:491, 1939.
2. Gilbert, N. C., and de Takats, G.: Emergency treatment of apoplexy. J.A.M.A., 136:659, (March 6) 1948.

(Continued on Page 1418)

Incidental Appendectomies

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IN THE Department of Obstetrics and Gynecology at the University of Michigan Hospital, incidental appendectomy has long been almost a routine procedure at the time of laparotomy. Unless some contraindication existed, this has been our regular practice. Because the pathology report returned on these appendices usually revealed the presence of chronic, and sometimes active, disease, the following questions were raised:

1. Is the appendix a readily, a repeatedly, and a chronically diseased structure?

2. Are we jeopardizing or benefiting the patient by the removal of the appendix at the time of major pelvic surgery?

With this in mind, 160 consecutive laparotomies for abdominal hysterectomy, a major pelvic procedure, were analyzed statistically.

Since appendicitis is commonly a disease of adolescence, we were interested in the age grouping of our patients. The extremes were twenty and seventy-one years. The average age was forty-four years, which is beyond the age of highest incidence for appendicitis.

Our 160 patients were divided into three groups, as shown in Table I.

TABLE I. APPENDECTOMIES IN RELATION TO HYSTERECTOMIES

Group	*No.*	*Percentage*
Appendectomy with hysterectomy	70	44%
Appendix already removed	48	30%
No appendectomy with hysterectomy	42	26%
Total	160	100%

In seventy (44 per cent) we performed an incidental appendectomy. Forty-eight (30 per cent) of our patients had already had an appendectomy in the past because of acute appendicitis or incidental to other surgery. Forty-two (26 per cent) did not have an appendectomy with our operation presumably because some contraindication existed.

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Since most of the appendices removed were reported as being the seat of chronic and sometimes active infection, we were of course interested in knowing whether clinical signs and symptoms of appendicitis had been present preoperatively in the seventy appendectomized cases in our series.

TABLE II. PREOPERATIVE SIGNS AND SYMPTOMS

Pain or tenderness in right lower quadrant	7
Nausea and vomiting	1
Temperature elevation over 99.6° F.	0
Leukocytosis over 10,000	0

In only seven (10 per cent) of these patients was there a history or clinical findings which might have been interpreted as indicating the presence of a diseased appendix (Table II). These signs and symptoms were usually attributed to other causes. In only two cases was one of the tentative preoperative diagnoses that of appendicitis. Whether these patients had had attacks of appendicitis in the past could not be determined by reading the patients' records.

Since most of the removed appendices were reported as pathological, we were interested in learning what the surgeon found at the time of operation. In the record most of the seventy appendices removed were described as benign in appearance, or else no description was given. In only nineteen (27 per cent) was some abnormality as to position, inflammation, fibrosis, vascular change, dilatation of the lumen, concretions, or adhesions noted. Fifty-one (73 per cent) were thought by the operator to be normal. In spite of the fact that in nineteen some abnormality was noted, in only one case was the clinical diagnosis of chronic appendicitis made.

Considering these facts, namely, the lack of preoperative signs or symptoms of appendicitis and, secondly, the absence of clinical or gross manifestations of inflammation in the appendix when viewed directly, the question arose as to what the pathologist saw through the microscope that was so indicative of recurrent and sometimes active infection in the appendices incidentally removed.

Table III divides into unit statements what the pathologist saw in the seventy appendices removed incidentally to pelvic surgery.

The crux of the problem lies in whether the changes listed represent evidence of repeated infections or changes coincident with age.

Fibrosis of the submucosa and/or the subserosa, present in forty-one of the appendices removed, may possibly be considered as a change of age. On

the other hand, structurally the appendix is essentially the same as the gut and we do not see this degree of fibrosis in the gut with age.

TABLE III. MICROSCOPIC REPORT OF SEVENTY APPENDICES

Fibrosis of submucosa and/or subserosa	41
Recurrent appendicitis and periappendicitis still active	35
Recurrent appendicitis and periappendicitis	30
Dilatation of appendiceal lumen	15
Fecal concretion or other foreign bodies in lumen	14
Lymphoid hyperplasia	10
Obliteration of distal ⅓ of lumen	10
Obliteration of distal ⅔ of lumen	4
Complete obliteration of lumen	8
Periappendiceal adhesions	8
Purulent exudate in the lumen	4

In sixty-five of the seventy appendices removed, the pathologist reported recurrent appendicitis and periappendicitis; in thirty-five of these some degree of active infection was noted. This was not a matter of professional courtesy since these were incidental appendectomies and the pathologist reported merely what he saw through the microscope.

If our theories as to the etiology of appendicitis are correct, then dilatation of the appendiceal lumen and fecal concretions or other foreign bodies in the lumen, present in fifteen and fourteen cases respectfully in our seventy appendectomized patients, represent factors that are, or can lead to, appendicitis.

Lymphoid hyperplasia is considered by some a prevalent coexisting factor in appendicitis because it is most pronounced in adolescence, the age of the highest incidence of appendicitis. Many theories exist as to the causal relationship between lymphoid hyperplasia and appendicitis, but most depend on the fact that lymphoid tissue readily becomes the focus of infection. We shall not attempt to decide that causal relationship here, but in our group, with an average age of forty-four, lymphoid hyperplasia was still pronounced enough to be remarked upon by the pathologist in ten (14 per cent) of the appendices removed.

Our next consideration was whether obliteration of the appendiceal lumen, present to some degree in twenty-two of our seventy appendectomized patients, represented an aging process or repeated infection. We believe that scar tissue sufficient to obliterate the appendiceal lumen is most likely to be the result of repeated infection. Certainly the gut does not become obliterated with age, probably in part because it is not the site of repeated infection.

Few, if any, physicians will dispute the fact that periappendiceal adhesions and purulent exudate in the lumen, present in twelve of our patients, do not represent aging. They do, however, indicate the presence of former or existing inflammation.

Considering the above pathological findings, the thought may arise as to what is a normal appendix. It would appear that a "normal" appendix in the age group represented by our patients is a chronically diseased one. If the same criteria for inflammation are used in viewing the appendix as with other organs, it is readily discernible as a chronically and sometimes actively diseased structure.

However, since our patients were sick to the extent of having pelvic pathologic conditions requiring operation, and since we do not have information concerning the health of the appendix in normal healthy women of the same age group, not operated upon, dogmatic conclusions on this point cannot be stated. Nevertheless, the implication seems pertinent.

Why should the appendix be the site of repeated active and chronic inflammation? Logically, the answer lies in the anatomy and physiology of the organ. The appendix is a diverticulum of the alimentary canal and similar to the bowel in structure. Its muscular coats favor contraction toward the outlet. The appendix is suspended by its own mesentery, the mesoappendix, and is freely movable unless fixed by adhesions. Its blood supply, the appendiceal artery, is a terminal vessel, has no anastomatic branches and runs through the free mesentery of the appendix. The nerve supply is from the superior mesenteric plexus which also sends numerous twigs to the small intestine.

Appendicitis may occur as a result of occlusion of the lumen, either by a foreign body or by angulation of the appendix itself, and the presence of organisms distal to that occlusion. The structure of the appendix predisposes to these conditions. Whether appendicitis resolves by building up sufficient mechanical pressure to remove the obstruction and thus obtain free drainage, or goes on to gangrene and perforation, depends upon the degree and cause of obstruction and the virulence of the organisms. Furthermore, with repeated infection, the columnar mucosa, the muscular coats and blood supply become impaired by fibrous tissue change and the appendix loses some of its ability to overcome subsequent infection. If the patient lives long enough, the fate of the appendix may follow one of two courses. Either, because of re-

peated attacks which subside, it becomes a fibrous band without a lumen or, so long as the lumen remains, the appendix continues as a source of potential danger for an acute fulminating attack that can lead to gangrene, perforation and possibly death.

If the appendix is the site of repeated infection, why is it not more manifest clinically as acute appendicitis? The answer may lie in the nerve supply to the appendix. The nerve supply comes from the superior mesenteric plexus which also supplies the small bowel. As is well known, the early manifestations of appendicitis are chiefly generalized abdominal symptoms. In those that subside, these are the only symptoms. It is only in the acute fulminating case with involvement of the visceral, but particularly the parietal peritoneum, that pain and tenderness become localized to the right lower quadrant and all the signs and symptoms of acute appendicitis, as we know them, appear. Appendicitis, in a subclinical state, may, therefore, be a more common cause of generalized abdominal symptoms than is generally realized.

The mortality from appendicitis in the United States is about 5,000 per year. It's true that most of this mortality occurs in adolescents, though it is not necessarily confined to that age group. This death rate, plus the fact that we have no statistics on the number of people with perforations without death who may remain gastrointestinal cripples for the rest of their lives, nor any statistics on the morbidity and lost man hours in cases of appendicitis which subside, makes it seem that this is rather a high price to pay for an organ of no known function.

If, as the evidence suggests, the appendix is commonly a chronically and sometimes an actively infected organ, are we increasing the hazards to the patient by removing it at the time of major pelvic surgery? The 160 laparotomies for hysterectomy were divided into three groups: (1) those having an appendectomy at the time of pelvic surgery, (2) those who did not have appendectomies at the time of our pelvic surgery, and (3) those previously appendectomized at an earlier date. To compare postoperative morbidity, we did not use patients on whom routine appendectomy was not carried out, since they represented a sicker group and this generally was the reason why appendectomy was not performed. However, we took the two groups of patients, those on whom we performed incidental appendectomy and those previously appendectomized, and compared them. Seventy patients had appendectomies with pelvic surgery. Forty-eight had previously had an appendectomy.

Since the hazards of removing the appendix are primarily those of infection, we used the criteria shown in Table IV for comparison in these two groups.

TABLE IV. POSTOPERATIVE MORBIDITY

	Appendectomy With Pelvic Surgery	Appendectomized at Previous Date
Peritonitis or pelvic infection	0	2
Thrombosis or phlebitis	2	2
Wound infection	3	3
Delayed wound healing	3	2
Fever over 100° F. after 2nd postoperative day	7	7
Evidence of infection elsewhere	1	1
Total	16	17
Number of Cases	70	48
Percentage	23%	35%

We realize that other factors can account for these complications, but by using the same criteria for both groups and by assuming that other factors will be equal, we should obtain some idea as to whether appendectomy increased the postoperative morbidity. From our figures it would appear that appendectomy does not increase the postoperative morbidity. In fact, the converse is true, as the appendectomized patients filled these criteria in only 23 per cent, while those who had appendectomies previously filled 35 per cent. However, these figures must be cautiously interpreted. Perhaps some contraindication existed in the second group so that we would not have done an appendectomy anyway, and, furthermore, our second group contained more patients with chronic pelvic inflammatory disease. These, as well as other factors, doubtless influence these statistics. All we can assume, from these data, is that postoperative morbidity does not seem to be increased by the removal of the diseased appendix at the time of major pelvic surgery.

Conclusions

1. In the age group represented by the patients in our study, the appendix appears to be commonly a chronically and sometimes an actively infected structure.

2. We believe that if the abdomen is opened for other indications, the appendix, if present, should be removed, unless, of course, contraindications to so doing are present.

3. On the basis of this limited study, incidental appendectomy does not appear to increase the postoperative morbidity.

Chronic Urethritis in Women

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THE TROUBLESOME female urethra has long been a source of annoyance not only to the general practitioner but to the gynecologist and urologist, to say nothing of the patient herself. This annoyance has, in a multiplicity of cases, risen to the realm of a definite medical problem. All of us, despite our utmost endeavors, have found the pathologic condition and accompanying symptoms a problem, which puts a severe strain on the physician's medical knowledge and ingenuity, and often causes the patient much physical discomfort and mental anguish. Too many such problems have in the past been dismissed as a neurosis or as a menopausal complex.

The lesions of the female urethra are many, and it is the purpose of this paper to discuss only one phase of the affliction of that small part of the female urinary tract which may give rise to a symptom-complex so familiar to all of us.

The female urethra is a short tubular structure, 3 to 5 cm. in length, extending from the bladder to the vestibule. The external orifice is the narrowest portion, usually slitlike, but at times shaped as an inverted Y. There is a mucous, submucous and muscular coat. The epithelium is stratified squamous except near the bladder where it becomes transitional. There are many small tubular glands in the proximal one-third and a few lesser ones in the outer one-third. The submucous layer is areolar tissue with elastic fibers and a network of venous spaces. The muscular coat consists of two layers, longitudinal and outer circular. The inner portion of the latter forms the internal sphincter. The voluntary sphincter is a layer of striated muscle fibers arising between two layers of the triangular ligament surrounding completely the urethra and extending to the vesical outlet.

Numerous investigators have contributed to the literature as to the size, position and distribution of glands. Caldwell[1] found glands in nearly all posterior urethras and concluded that they were counterparts of the prostate glands in the male. MacKenzie and Sing[7] after serial section found in the anterior one-third and occasionally middle one-third peri-urethral tubular structures distinct from Skene's glands. Roeser and Kretchmer[10] called attention to Skene's glands as an often overlooked cause of urinary symptoms and stated that temporary relief by instrumentation by sounds or the cystoscope was often obtained as a result of the pressure of these instruments on the infected glands causing the expression of retained discharge. Maximov and Bloom[8] demonstrated within the epithelial lining of the bladder neck, intra-epithelial glands which do not cause the epithelium to bulge nor cause the basement membrane to project into the connective tissue. In a clinico-pathological study of 100 female urethras which showed no evidence of obstruction, Lentgen and Herbert[6] found glands in every case in the anterior urethra and in 65 per cent of the posterior urethras. Their most constant pathological finding in the female urethra was that of cystic degeneration, and they believed that it was difficult to eradicate because of the presence of these cysts in the transitional epithelium of the urethra. Hyperplastic change at the vesical neck in the female is frequently associated with marked urinary disturbance and pain, the diagnosis of which is based on careful urethroscopic investigation.

This anatomy in itself may be a predisposing factor in the presence of the pathologic condition under discussion. Winsbury White[12] experimentally injected India ink into the deep cervical tissues and demonstrated, by post-mortem serial section studies, lymphatic connections between the cervix, base of the bladder and the kidneys. The fact that the mere passage of a sound into the deep urethra, either in the male or female, may be followed by systemic reaction as a chill, fever and even renal tenderness, has undoubtedly been observed by all urologists. Before the advent of streptomycin, penicillin, and the sulfonamides, it was noted that operations about the bladder neck might be followed by renal sepsis, particularly when the operation was done to correct an inflammatory lesion.

Observation and treatment of pathologic conditions of the urethra and trigone have been greatly simplified by the almost universal use of the for-oblique lens which gives the observer a clear picture of the urethra and its analoge, the trigone. Cystoscopically, submucous injection of the trigone, the so-called trigonitis extending from the posterior

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vesical lip to one or both ureteral orifices, is seen to extend out into the urethra and should be interpreted as a lymphangiitis.

Factors contributing to chronic urethral lesions may be divided into three groups: (1) previous urinary tract infections, (2) genital tract infections, and (3) a combination of the first two. Rarely in our experience have we found a distant foci of infection to be responsible and none in the present series. In our first group it is noteworthy that 50 per cent of the patients date their symptoms from catheterization following surgery or delivery. Whether or not infection was introduced at that time, or trauma or carelessness was responsible, is impossible to decide. In our opinion the presence of a small meatus, necessitating meatotomy before a No. 24 F. pan-endoscope can be introduced, is definitely a predisposing factor. It further adds significance to the old adage as applied to the urinary tract that treatment of infection is of no avail unless obstruction is removed. Deakin[3] pointed out that no amount of urologic manipulation of the urethral mucosa may reasonably be expected to affect a permanent cure of a chronic urethritis so long as sagging of the bladder and the consequent angulation of the bladder and urethra persist. His experience was that electrocoagulation of areas of granulation tissue or of tabs in the urethra was followed in practically every instance by a most gratifying return to normal in the appearance of the mucosa, as well as by a relief from symptoms. Acute infections of the urinary tract, specifically pyelonephritis, concern us here only in that they may be precursors of chronic lesions.

In our second group the most outstanding contributing factor was a cervicitis. It has long been recognized that cervicitis and cystitis occur simultaneously. It has been the speaker's experience that it is a problem of great magnitude to convince some gynecologists that a low grade cervicitis can be responsible for a patient's urinary symptoms and that measures should be taken to correct what to the gynecologist appears to be an insignificant physiological entity. Pregnancy, abortion, gonorrheal infections and pelvic infections are very potent factors in the production of changes in the lower urinary tract.

Our third group presents a combination of the aforementioned and is particularly important from a treatment standpoint. Treatment of only the urinary lesions or only the gynecological lesions is only a temporary expedient and, while it may result in temporary relief of symptoms, does not eradicate the pathology. Thirty per cent of our cases had had previous gynecological surgery, which to some extent gave temporary comfort, but recurrence of symptoms sent them elsewhere for relief. Close co-operation between the urologist and the gynecologist is essential.

Very briefly, I should like to present some of the findings observed in sixty-eight cases which have come under our observation. The presenting symptoms of all were frequency, burning on urination, chiefly terminal, urgency and nocturia. As a rule these symptoms were intermittent, coming on suddenly in attacks, occurring from once a year in one instance to twelve times a year as the most frequent. The average duration of symptoms was eight years. The severity of the attacks had no relation to the frequency, and in only four instances did it coincide with or follow menstruation. It was felt that the two most common factors noted in each history were first, a gastrointestinal upset, and second, a more marked vaginal discharge than had been previously noted. In three instances Trichomonas vaginalis were found in the vaginal secretion, but none was ever recovered from the catheterized urine.

Symptoms were most marked when the patients were doing their daily work. Frequency and urgency were the chief complaints, the latter being so severe that incontinence was present in 8 per cent of the cases. Nocturia regardless of fluid intake was present in every case, varying from one time a night to every hour. Eight cases gave a history of hematuria, of which seven were terminal and associated with severe pain. Ten cases stated that they had lower abdominal discomfort, described as a bearing-down sensation. Forty-nine patients complained chiefly of burning on voiding or pain supposedly urethral in origin. Four complained of backache in one or both costovertebral areas. Forty-three of these patients were married, twenty-one, widowed or divorced, and four, unmarried.

On examination, forty (approximately 50 per cent) complained of tenderness of the urethra on palpation and were distressed by the passage of a catheter. Of the cervices examined, twenty-seven (40 per cent) showed definite evidence of infection. Eighteen patients had pelvic relaxations, of

which eight had been repaired. In all cases catheterized urine specimens were obtained, and in forty-four these were found to be crystal clear with only a few pus cells per high-power field. The remainder were found to have many bacteria and white blood cells with few to many red blood cells. Meatotomy was necessary in forty-three cases before a McCarthy No. 24 pan-endoscope could be passed. In only one case were we able to definitely diagnose a true stricture back of the obstruction at the meatus. One slight urethrocele was noted which had been repaired elsewhere. In this case the slight sagging of the floor was not thought responsible for her symptoms. She went elsewhere for dilation of the urethra after fulguration, and another surgeon operated on her for this condition for the second time, and he reported that her symptoms had been entirely relieved. Forty-eight cases received upper urinary tract work-ups, and in twenty-six of these we were able to obtain one of the following organisms from the bladder or from one or both kidneys: E. coli, ten; mixed organisms, nine; staphylococcus, six; streptococcus, one. Upper tract pathology must constantly be kept in mind and the following conditions were found: pyelonephritis in nineteen cases, nephrolithiasis in two cases, ureteral stricture in one, nephroptosis in three, interstitial cystitis in one.

Authors have differed as to the best method of treatment in these types of cases. Everett[4] describes a small series of cases where dilatation and instillation of $AgNO_3$ were of no avail. He believed that post-menopausal patients with vaginal and urethral findings were best treated with vaginal suppositories of amniotin. As an explanation of the pathology, Folsom[5] suggested that at the menopause the estrogen-androgen imbalance may cause a glandular proliferation. This, however, does not account for the symptoms presented far before the menopause. Cook[2] felt that fulguration of the urethra was of little value and that extensive treatment resulted in extreme inflammation and cicatrization. Spense[11] used fulguration of the entire mucous membrane followed by dilatation to No. 34 F. The writer, in conjunction with L. W. Riba and Frank Christensen[9] some years ago, working at Northwestern University Medical School, reported various lesions of the female urethra and our method of treatment. Following fulguration we dilated these cases to an average of No. 35 F.

At present our procedure, following the preliminary steps before mentioned, is to work up the higher urinary tract if there is any evidence at all that this might be the causative factor in bladder neck complaints. To our regret we have discovered that in three instances, upper tract pathologic conditions have been missed because we felt we did not have sufficient evidence to subject the patient to such investigation. We do a meatotomy when indicated, and a careful examination of the entire bladder and urethra is made with a No. 24 McCarthy pan-endoscope. All cysts and granulations on the urethra and trigone are fulgurated with a light current. This current is sufficient to cause blanching of the mucous membrane, but not strong enough to injure the musculature beneath. It is well known that any current will cause destruction or at least temporary injury to tissues which cannot be visualized so extreme caution is necessary in the degree of fulguration used. This maneuver is carried out rapidly and easily with the instrument mentioned. We have arbitrarily set a three-week period before any further instrumentation is done. Our meatotomy is usually generous so that we have as yet had no difficulty in introducing a No. 26 F. Van Buren sound on the first postfulguration visit. We have limited ourselves to gradual dilatations until a No. 30 F. is reached and have contented ourselves with this size, rather than go to the No. 35 F. by means of the Kollman dilator which we formerly believed necessary.

Our results have been most gratifying, yet we must admit that in private practice a complete follow-up has not been practical as when dispensary patients were investigated. In sixty out of the sixty-eight cases, almost complete immediate relief was noted. The remaining eight reported as follows: Two were slightly better, one unchanged, and five made temporarily worse by the fulguration. Of the sixty cases, forty-six had no recurrence of symptoms until sounds were passed which caused a recurrence of symptoms, lasting as a rule for forty-eight hours but in one case persisting for six days. The case of interstitial cystitis received temporary relief which we now believe due to bladder dilation under anesthesia, but her symptoms recurred in six weeks and were only relieved by fulguration of a small ulcer and bladder dilation. As yet, it is too early to consider our results in this case, but it is interesting to note that in the second cystoscopy the granulations were

no longer present in the urethra. Of the forty-six cases which had no recurrence, we have been able to follow only thirty-nine of them for one year with any accuracy. Sixteen (41 per cent) consider themselves completely cured, i.e., have had no recurrence of symptoms. Ten (25 per cent) state they have been markedly improved. Eleven (28 per cent) have been slightly improved, while two (4 per cent) have not been benefited. The latter have had but one cystoscopy and fulguration. In all cases, attempts were made to correct pathologic conditions outside the urinary tract.

1. A résumé of sixty-eight patients with chronic urethritis is presented.

2. With a careful history, physical examination and urinalysis, a pathologic urethral condition may be suspected.

3. The absence of gross and microscopic findings in catheterized urine in the female, together with a history of long standing vesical irritation, is an indication for a complete urological work-up with special attention directed to the urethra.

4. The detection and correction of urethral lesions which occur more often than is realized is a major urologic problem.

5. Our method of diagnosis and treatment of this condition has been presented.

6. It is suggested that suburethral chronic infection may be responsible for pathologic conditions in the higher urinary tract.

References

1. Caldwell, George T.: The glands of the posterior female urethra. Texas State J. Med., 36:627-32, 1941.
2. Cook and Hodgson: Certain conditions of the female urethra. M. Clin. North America, 29: No. 24, (July) 1945.
3. Deakin, Rogers: Chronic urethritis in women. South, M. J., 38:1, (Jan.) 1945.
4. Everett, H. S.: Diseases of the urethra in the female. Am. J. Obst. & Gynec., (June) 1941.
5. Folsom, A. I.: The female urethra, J.A.M.A., 97:1345-51, 1931.
6. Lentgen and Herbert: A clinico-pathological study of 100 female urethras. J. Urol., (March) 1946.
7. MacKenzie and Sing: Common conditions of the neck of the female bladder. Canad. M.A.J., (May) 1939.
8. Maximox and Bloom: Textbook of Histology. 4th ed. Philadelphia: W. B. Saunders, 1942.
9. Riba, Christiansen and Hibbs: Management of lesions of the female urethra. Illinois M. J., (Jan.) 1936.
10. Roeser and Kretchmer: Infections of the female urethra. Illinois M. J., 88:273-322, (Dec.) 1945.
11. Spense. Granular urethritis in women. J. Urol., 43:199, (Jan.) 1940.
12. White, Winsbury: The spread of infection from the uterine cervix to the urinary tract and the ascent of infection from the lower urinary tract to the kidneys. Brit. J. Urol., 5:249-67, 1933.

Emergency Eye Care in General Practice

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OCULAR INJURIES constitute but a very small part of the multitude of conditions those in the general practice of medicine are called upon to treat. Because of their relative infrequency, however, the physician is often at a loss as to the proper approach in their managment. This feeling of hesitancy is heightened by the realization that improper care may cost the patient his eyesight. It is not always possible nor always necessary to refer these patients to those especially interested in eye care since most ocular emergencies can and should be cared for by those who first see the patient. Delay caused by sending the patient some distance to a specialist may in itself result in a poor outcome. With such a thought in mind, let us review some of the more common emergency ocular conditions and make some suggestions that may help in obtaining a good result.

Probably the most common eye condition seen in general practice is the corneal foreign body. In removing the foreign substance it is necessary to have adequate anesthesia, good illumination, and good magnification. Without these aids the operator is more than likely to scrape off a large area of corneal epithelium and thus add to the severity of the patient's injury. Adequate anesthesia is best obtained by drugs such as 1/2 per cent pontocaine, which does not soften the corneal epithelium and thus promote epithelial stripping, such as is obtained with cocaine. A Beebe binocular loupe and small pencil flashlight, together with an assortment of sterile foreign body spuds, complete the equipment. If foreign body spuds are not at hand, a small sterile hypodermic needle on a small luer will suffice. Many foreign bodies can be removed by simply brushing them off the cornea with a wet cotton applicator. It is necessary to remember that the charred tissue about the actual foreign body must be completely removed if the lesion is to heal. It is my practice to instill butyn-metaphen ointment and pad these eyes for

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a few hours following foreign body removal. If there is ciliary injection and the area of trauma in the cornea is hazy, uveitis and ulceration are probably present and the patient might better be turned over to your ophthalmologist. Foreign bodies imbedded in an area 6 mm. in diameter in the center of the cornea must be handled with great respect since this area is the optical zone of the cornea. Even faint scars of this zone will result in considerable permanent visual loss.

Corneal abrasions undoubtedly are next in order of frequency. These are often missed by the examiner if the abrasion is not stained with 2 per cent aqueous fluorescein. Abrasions usually heal readily in a day or two by instilling some combination ointment such as butyn-metaphen or metacaine-merthiolate and tightly padding the eye.

Blunt, nonperforating, contusive injuries to the eyeball are rather frequent among children. Fortunately the protection afforded by the bony orbital rim prevents most of these injuries from doing serious harm. The plebian black eye is best treated, if seen immediately, by applying continuous ice compresses. This will largely control the edema. Hot wet compresses may be preferred if the process is seen later when edema is present. The heat will merely hasten the absorption of blood. If it is necessary for the injured individual to make a public appearance, the discoloration of the lids may be masked by the use of the cosmetic labeled "Cover Mark," which may be secured from any beauty parlor.

Contusive injuries to and about the eye should not be passed over lightly, however, until the orbital rim and interior of the eye have been thoroughly searched for more serious damage. Fractures of the orbital rim showing considerable displacement may result in displacement of the eyeball and disturbances in its motility. Such displaced fractures should be replaced at once or as soon as the edema has subsided.

A subluxated lens, resulting from contusion, will not respond to treatment, but by discovering its presence embarrassment to the examiner may later be avoided. The same is true as regards vitreous hemorrhage or ruptures of the choroid. When the latter conditions are found, the eye should be watched for development of retinal detachment. Should detachment of the retina occur, immediate ophthalmological care is imperative.

Blunt injuries to the globe not infrequently are followed immediately or later by massive anterior chamber hemorrhage. The complication is one which requires careful observation, and unless you are sure of your grounds, you might better shift the responsibility to an ophthalmologist. Most anterior chamber hemorrhages will absorb fairly readily with the use of 1 per cent eserine or 2 per cent pilocarpine four times daily, together with hot compresses. Others may persist or result in a secondary rise in intraocular pressure. Since this pressure, in the presence of anterior chamber hemorrhage, leads to the development of blood staining of the cornea, the increased pressure must be relieved immediately by corneal paracentesis. The use of eserine or pilocarpine will have no influence on the pressure, and valuable time should not be lost in trial. I have yet to see an eye showing blood staining of the cornea which eventually obtained useful vision. I have not seen blood staining of the cornea result from anterior chamber hemorrhage when there was no increased ocular pressure. These two observations emphasize the necessity for early recognition and correction of the glaucoma in this type of ocular trauma.

The anterior chamber hemorrhage from blunt nonperforating contusion to the eyeball often results from lacerations of the iris. The weakest part of the iris is its attachment to the ciliary body. Laceration of the iris at this point results in a pulling away of the iris at its base. If this is severe the pupil is usually strongly displaced towards the opposite side. Slight to moderate displacement of the pupil gives no visual impairment, but marked pupillary displacement gives marked loss of vision. These latter cases indicate the need of surgical correction.

Perforating injuries to the eyeball by flying particles point to the desirability of x-ray of the globe. X-ray of the eye should be done in all instances in which the history suggests the possibility of an intraocular foreign body. Many of these eyes have an obvious perforation of the globe, but in others careful search reveals no point of entrance. An undiscovered intraocular metallic foreign body may give no symptoms for years. More commonly they result in recurrent iridocyclitis, endophthalmitis, cataract, or siderosis bulbi. Once the retained foreign body has rusted away and the rust disseminated through the eyeball, the globe goes into phthisis. Those physicians connected with industrial first aid stations or those not especially interested in eye care should not burden

themselves with the responsibility of caring for these patients. A fairly high percentage of enucleations eventually follow perforating ocular injuries.

With the advent of relatively inexpensive ultraviolet lamps, their use in the home is becoming more common. The users of these lamps sooner or later become careless and do not adequately protect the eyes while taking a sun bath. Since the eyes are sensitive to infrared and ultraviolet rays nearest to the visible spectrum, we occasionally see these people with violent edema, photophobia and pain. No permanent damage is produced by this severe reaction, but adequate care is needed to give comfort. Ice compresses, dark room, and the instillation of phenocaine-epinephrine ointment (Upjohn) will give almost complete relief. Arc welders and electricians receive similar types of electric ophthalmia.

There are many types of chemical burns involving the eyes, and, in general, they are to be considered as serious. The alkalies are usually more damaging than the acids in that they have a tendency to keep on working deeper and deeper into the tissues while the acids coagulate the proteins of the surface cells and thus produce a more superficial lesion. Cicatricial contraction of the conjunctiva results in symblepharon of varying degrees.

The first treatment is the most important. Speed and thoroughness are the main requisites for a satisfactory end result. Chemical burns should be treated immediately by copious washing with tap water. The more water used, the better. Care must be used to evert the eyelids no matter how serious the blepharospasm. Only too frequently the plaster, lime or other chemical is left in the retrotarsal folds to act over a long period of time. No attempt should be made to neutralize an acid with an alkali, et cetera. Adhesions should not be allowed to form between bulbar and palpebral conjunctiva. By passing a small smooth glass rod covered with vaseline between the lids and globe once or twice daily symblepharon may be prevented.

Lacerations involving the margin of the eyelid require immediate and accurate repair if cosmetic defects and functional disturbances are to be avoided. Most of the textbooks on ophthalmic and plastic surgery deal with methods of correcting the late deformities which result from lacerations of the eyelids. More emphasis should be placed on methods of preventing deformities resulting from recent lid trauma. The physician who first cares for these patients has the best opportunity of giving a good cosmetic and functional lid. Lack of appreciation of this fact often results in hasty and bungled repairs which later have to be reoperated upon with less chance of a satisfactory result.

Lacerations of the eyelids may be of relatively minor importance compared with the shock and other more serious trauma which the patient may have coincidently. Rather than make hasty and inadequate repairs under these circumstances, the eyeball should be covered, if exposed, and the repair of the lid lacerations left until a time when more meticulous care can be expended on their suturing. The longer the interval between injury and repair, the more edema is present. This edema distorts the tissues of the lids and, to some extent, complicates the surgery. If ice compresses are kept on the lids until the surgery can be started, much of the edema can be prevented.

Extramarginal lacerations require more care than do lacerations elsewhere on the body surface. It is necessary to recall that there is very little tension on the tissues of the lids, and therefore much finer sutures and needles should be used to give the least possible scar. Use 6-0 black silk with atraumatic needles for all skin and conjunctival repairs of this type. No silk or gut sutures or knots should ever be allowed to come into contact with the cornea from the inner surface of the lid. For proper lid action it is imperative that extramarginal lacerations severing orbicularis muscle bundles be reunited as a layer. This is best done with 5-0 mild gut sutures on atraumatic needles. When the levator tendon is severed, it should be isolated and sutured with 5-0 medium gut to prevent ptosis. It is far more difficult to make this correction in a healed deformity. If meticulous cleansing of the wound is carried out, no drainage tubes need be inserted. Only crushed tissues are excised.

Transmarginal lid lacerations, on the other hand, require even more meticulous repair if the results are to be both cosmetic and functional. Here again we must stress the need for using the fine sutures and atraumatic needles and the least debridement possible; 6-0 silk is used on the skin surface, and 5-0 or 6-0 gut is used for the buried sutures.

The most important suture (Fig. 1) to be placed is that uniting the intermarginal groove. This is the grey line situated between the openings of the

Meibomian glands and the eyelashes. If the first suture placed passes through this line down into the substance of the tarsus and then across the line of laceration to enter the tarsus at the same

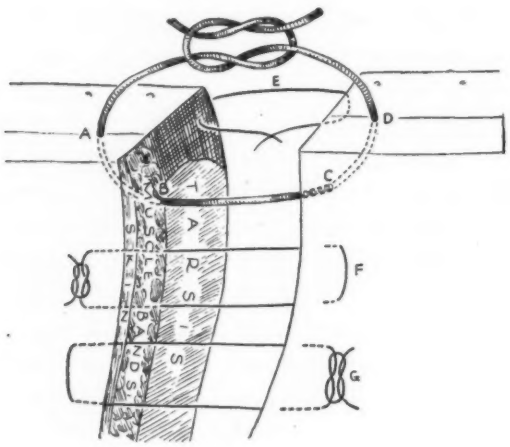

Fig. 1. Transmarginal laceration of lower eyelid. (A, B, C, and D) points of entrance and exit of suture uniting intermarginal groove; (E) deep buried gut sutures uniting tarsal plate; (F) sutures uniting orbicularis muscle bundles, either buried or not; (G) cuticular sutures.

distance from the lid border and comes out in the intermarginal line on the other side of the laceration, the lid border will be in perfect alignment. This enables us to insert accurately the deep buried gut sutures closing the tarsoconjunctival surface and the superficial silk sutures closing the orbicularis muscle and skin. Silk or gut sutures or knots should never be left in contact with the corneal surface, since the movement of the globe will cause abrasion and scarring.

Minsky[1] has made helpful suggestions which aid in obtaining smooth union of the lacerated lid border. He splints the two lid borders together by passing the sutures uniting the lacerated lid margin through the opposite contacting lid border and then brings the sutures out through the skin above the lashes; tying them over a rubber plate. Where more than one laceration of the lid border is present this splinting suture method of Minsky may be utilized with advantage. Should the transmarginal lid laceration involve both lids at the same point, Minsky's figure eight suture[1] may be used. This gives perfect alignment and splinting of both lid borders. The deep buried conjunctivotarsal gut sutures and the superficial musculocutaneous silk sutures are inserted as previously mentioned.

Special precautions are necessary when lid lacerations involve the lateral or medial canthus. Should the lateral canthal ligament be severed or evulsed, the lids are not held tightly against the globe and epiphora and ectropion will result. It is therefore necessary to see that strong 4-0 gut sutures unite

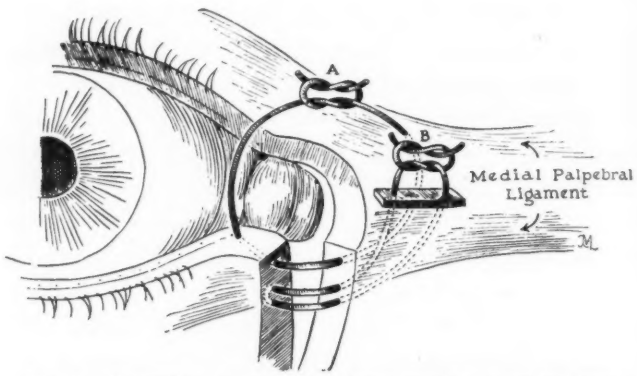

Fig. 2. Laceration of eyelid at inner canthus, severing lower lacrimal canaliculus. (A) heavy chrome gut suture threaded through the canaliculus and into the lacrimal sac, coming out through the skin at the upper pole of the sac; (B) traction suture anchoring severed lid to the internal palpebral ligament. Deep conjunctival gut sutures, orbicularis muscle sutures and skin sutures inserted in layers to close remainder of lid defect.

the severed ends of the ligament. Should there be tissue loss and the ligament not identified, the outer ends of the tarsal plates should be united by sutures with the periosteum behind the lateral orbital rim at the point conforming to the lateral canthus. The orbicularis muscle fibers near the lid border should be included in the cutaneous sutures, since these muscle fibers play an important role in keeping the lid border from turning out in ectropion. The intermarginal sulcus is again utilized in lacerations at the lateral canthus, since a suture passed through this line below the canthal laceration and then across the laceration to come out in the intermarginal sulcus of the other lid will perfectly reform the canthal angle.

Lacerations and evulsions of the medial canthus involve even more important anatomical structures, since only too commonly the lacrimal passages are severed. Unless the medial canthus is properly restored and the lacrimal passages remain patent, troublesome epiphora results.

When the laceration goes across the lower canaliculus, a heavy chromic catgut suture is threaded through the punctum and canaliculus and through the medial cut end of the canaliculus and into the lacrimal sac (Fig. 2). The needle is brought out through the upper pole of the lacrimal sac and through the skin above the internal palpebral ligament and tied.

It is necessary to anchor the inner end of the severed lid to the internal papebral ligament or

periosteum. This is best done by passing a double armed No. 2 braided silk suture through the conjunctival surface of the torn lid to come out below the severed canaliculus. These sutures are then passed through the torn medial lid tissues below the canaliculus and directed upward to engage the canthal ligament in an attempt to anchor the lid at this point. These sutures are brought out through the skin and tied over a rubber plate (Fig. 2). The skin and orbicularis muscle are united in layers after the depth of the wound is closed with buried gut, as in the transmarginal lacerations.

Summary

Ocular injuries should receive immediate meticulous care. The majority of such injuries can and should be the responsibility of the physician first seeing the patient. The simplest of ocular trauma may result in loss of eyesight, but this can usually be prevented by following a few simple rules of ocular care. Lacerations of the lids cannot be sutured in the same manner as simple lacerations elsewhere on the body surface. The peculiar and complex anatomy of the eyelids must be maintained if function is not to be disturbed.

Reference

1. Minsky, Henry: Surgical repair of lid lacerations. Surg., Gynec. & Obst., 75:449-456, 1942.

MSMS

MORE MEN AND BOYS DROWN

While women's deaths by drowning increased more than 50 per cent in 1947, the fact remains that nine out of ten people who drown in Michigan are men and boys.

There were thirty-nine women and girls among the 307 persons who drowned in Michigan in 1947. There were twenty-five women and girls among the 265 persons who drowned in the state in 1946.

Two-thirds of the drownings in the state occurred during the three summer months, June, July and August. However, the larger share of deaths during these months did not occur at swimming beaches and nearly as many occurred in rivers as in lakes.

Lakes took the lives of ninety-seven persons; rivers, eighty-three persons; boating accidents, forty-three persons; and quarries and miscellaneous places, eighty-four persons.

Nearly half of the river deaths were of children under fifteen years of age. Lake deaths were about equally divided among those over and under twenty-five years of age. Boating accidents were concentrated in the fifteen to forty-five years age group. Twenty-three of the thirty-nine women and girls who drowned were under fifteen years of age.

Diagnosis of Early Uterine Cancer

By Harry M. Nelson, M.D.
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THERE HAVE BEEN no recent developments in cancer treatment. The emphasis today is on early diagnosis, to find the lesion at the very start when it is almost always curable by surgery, x-ray or radium. This is true of all cancer. Since we can discover cancer of the uterus early and relatively easily, it becomes possible, even without improving present methods, to cure most cases. Cancer of the uterus was responsible for 17,152 deaths in the United States, 710 in Michigan, during 1945—a death rate which indicates that there has been no appreciable decline in recent years. It is estimated that 62 per cent of all cancers occurring in women are in the breasts, pelvis, skin or rectum. Periodic physical examinations, by a physician on the alert to recognize early signs of cancer, should reveal most suspicious or early lesions in these areas without any special diagnostic aids. This indicates that routine annual or semiannual examinations in all women over thirty is an ideal goal in preventive medicine, though difficult to obtain.

Late diagnosis is the basic reason for failure in curing uterine cancer. This may be due to the physician's indolence or to the fear, ignorance and the natural inclination to procrastinate on the part of the women. The American public has, however, been aroused as never before to the danger of cancer and the need for seeking periodic examinations and aid at the earliest sign of danger. The doctor must do his part. Physicians have in the past approached the problem of periodic examinations without enthusiasm, because they have associated applicants too often with introspective, neurotic and apprehensive individuals. Because of the cancer educational work throughout the nation, we may expect to encounter more and more patients requesting periodic examinations who are genuinely interested in cancer diagnosis and prevention. These patients will seek physicians who are sympathetic to the problem and willing to give the deliberate and painstaking examination the public is being educated to expect. Routine examinations for well persons and cancer detection centers are

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part of the educational program of such organizations as the American Cancer Society. These clinics or centers focus the attention of women on the importance of periodic examination. They will eventually, we hope, make every doctor's office a detection unit. If every woman had a competent examination every six months with proper treatment when indicated, the mortality due to cancer of the uterus would take a spectacular drop.

Etiology

Most statistical studies indicate that carcinoma of the endometrium is much less frequent than carcinoma of the cervix; it was formerly estimated at twenty to one. In our hospital there is one carcinoma of the endometrium for every 3.45 of the cervix.

TABLE I. INCIDENCE OF CARCINOMA OF THE FUNDUS UTERI AND CERVIX UTERI, 1935-1946

	Number of Cases	Incidence Per Cent
Adenocarcinoma of fundus uteri	98	22.05
Adenoacanthoma of fundus uteri	2	.45
Squamous cell carcinoma of cervix uteri	318	71.5
Adenocarcinoma of cervix uteri	26	5.8
Total	445	100.00

Ratio of Carcinoma of Cervix to Fundus Uteri, All Ages, 3.45 to 1
Woman's Hospital, Detroit, Michigan

However, the Connecticut studies in a large series of cases show that endometrial carcinoma is much more frequent, the incidence there being three of the cervix for every two of the endometrium. Cancer of the cervix reaches its peak between the ages of forty and forty-five. Hence, it usually comes before, not after, the menopause. Though cases are found in elderly women and rarely in childhood, the highest index of suspicion should be held with respect to women in middle life, between the ages of thirty and sixty. Endometrial carcinoma is a disease that occurs most frequently during and after the menopause, the average age being about fifty-six years.

While the cause of cancer is unknown, there is some evidence that it may be an intracellular rather than an external factor. In many cases, a genetic factor and hormonal disturbances may be the predisposition which permits chronic irritation (external factor) to set off the uncontrolled growth. Gynecologists have taught for years that chronic irritation of the cervix predisposes to carcinoma. It is questionable whether pregnancy or labor plays any part in the development of cancer of the cervix. However, it is felt that the correction of common lesions of the cervix by conization, cauterization or amputation is a prophylaxis against the disease. In other words, cancer does not seem to occur commonly in the healthy cervix.

It probably is not possible to produce carcinoma of the uterus by means of estrogen treatment; at least, there are no authenticated case reports in the human being. It is known, however, that the estrogens do have carcinogenic effects in some animals and tissues. Since there is this uncertainty, estrogen therapy should be used very carefully or not at all in patients who have hereditary or other factors which might act as a predisposition to the disease. No patient should be given estrogens who has not had a careful examination. Delayed menopause is an indication of aberrant endometrial activity and a warning of a tendency to endometrial malignancy.

Symptoms

The most important symptom in history taking is the type of abnormal discharge. Cancer of the cervix is a particularly treacherous disease. In its early and curable stage it may cause little or no symptoms which may direct the attention of the patient or her physician to the condition. The three chief symptoms are leukorrhea, bleeding and pain, occurring in the order named. The vaginal discharge at first may differ from the normal vaginal secretion only in quantity. It may be a watery, serous or purulent discharge. Later, it may be somewhat bloody and of a characteristic watery consistency. Bleeding is usually the result of erosion of capillary blood vessels by the new growth, or it may be the result of trauma and follow intercourse, vaginal douching or vaginal examinations. A long history does not necessarily mean an advanced lesion, nor a short history an early one. Extent of the lesion depends more on the type of cancer than on the length of time. Pain, unfortunately, is a relatively late symptom and is, therefore, of little value in arriving at an early diagnosis.

In carcinoma of the endometrium, the menstrual cycle may be longer and the amount of bleeding greater. The menopause may be delayed, or an abnormal amount of bleeding may occur at this time. The appearance of spotting or irregular bleeding in the postmenopausal woman is always suggestive of cancer. Uterine hemorrhage in a woman beyond the menopause is positive evidence of cancer until thorough examination demonstrates conclusively that no malignancy is present.

In a recent study of 369 consecutive case histories of women, forty-nine years of age or older,

TABLE II. ABNORMAL VAGINAL BLEEDING IN WOMEN PAST AGE FORTY-NINE—MALIGNANT LESIONS

Location of Lesion	Number of Cases	Incidence Per Cent
Carcinoma of cervix	68	55.7
Carcinoma of corpus	42	34.5
Carcinoma of ovaries	4	3.3
Carcinoma of vagina	5	4.1
Pseudomyxoma Peritoneii	1	0.8
Carcinoma of vulva	2	1.6
Total	122	100.0

Ratio of carcinoma of cervix to fundus uteri past age 49, 1.6 to 1
Woman's Hospital, Detroit, Michigan

TABLE III. ABNORMAL VAGINAL BLEEDING IN WOMEN PAST AGE FORTY-NINE—ALL LESIONS

Type of Lesion	Number of Cases	Incidence Per Cent
Malignancy	122	33.0
Persistent Proliferative Endometrium	56	15.2
Atrophic Endometrium	34	9.2
Endometrial Polyps	41	11.1
Cervical Polyps	11	3.0
Leiomyomata Uteri	42	11.4
Cervicitis	20	5.4
Miscellaneous	43	11.7
Total	369	100.0

33% of all patients over 49 entering hospital because of bleeding had cancer.
Woman's Hospital, Detroit, Michigan.

who were admitted to Woman's Hospital because of abnormal vaginal bleeding, there were 122 cases of malignancy, representing 33 per cent of the total series. The possibility of a corpus carcinoma should always be suspected in menopausal or postmenopausal women seeking advice for symptoms produced by fibroids of the uterus.

Examination and Diagnosis

In practically all cases the cause of bleeding can be definitely established by a careful history and thorough pelvic examination, curettage and microscopic examination, assuming, of course, that there is no extra-uterine pathology evident. Over 90 per cent of the cases of cancer of the cervix can be diagnosed by the physician who does a bimanual examination, a careful inspection, and takes biopsies of any suspicious lesions. It is not enough to examine the pelvis only when symptoms arise. A careful bimanual examination should be part of every physical examination.

The inspection of the cervix should be carefully and properly done. There must be satisfactory exposure and adequate illumination. A good speculum examination is possible in most instances because the majority of patients have a marital outlet. Vaginal inspection must be made with deliberation and according to plan. If abnormal bleeding is present, the blood may be seen coming from the cervical canal, in which case a diagnostic currettage is definitely indicated to determine the presence or absence of intra-uterine or intracervical pathology.

The diagnosis of frank cancer of the cervix is easy. At first it is a small, red, irregular, elevated, circumscribed growth situated at, or near the external os, which when touched with a pointed instrument, such as a probe, penetrates and bleeds readily. To the palpating finger, the area feels slightly raised, granular and somewhat indurated or hard.

Unfortunately, there is no gross picture that is pathognomonic of the very early cervical cancer. Diagnosis of cervical carcinoma which is pre-invasive or so-called carcinoma *in situ* is often very difficult. There is no typical gross appearance of the earliest lesion before ulceration. It may be a very small hard area or it may look like a polyp. Any of these areas should be excised for microscopic examination. Naked eye study remains the most dependable method in the recognition of questionable areas which may require biopsy. Get a biopsy in a patient with postcoital bleeding even though the cervix appears normal. It has been often shown that cellular changes develop in the surface stratified squamous epithelium of the vaginal portion of the cervix which are regarded as the early manifestations of malignant transformation. That these changes occur before there is clinical evidence of carcinoma has been demonstrated many times. The epithelial cellular changes are similar in non-invasive and early-invasive carcinomas in areas not yet frankly or clinically carcinomatous, and closely resemble the changes found in the epithelial cells of frankly or clinically carcinomatous lesions.

We recently presented fifteen cases of intra-epithelial carcinoma of the cervix. The removal of the cervix with the body of the uterus disclosed most of these cases. The cure rate should be 100 per cent. Such cancers are rarely recognized except microscopically. It illustrates the importance of frequent biopsies and vaginal smears. Since the above study, we have, in a large series of vaginal smears, been able to diagnose several cases of non-invasive carcinoma. Biopsy showed the intra-epithelial lesion. Treatment has certainly cured these individuals. Non-invasive cancer of the cervix may be latent for years; then, for some unknown reason the growth appears to be accelerated and the cancer becomes infiltrative. Before doing a hysterectomy for a diseased uterus, a pelvic examination under anethesia, biopsy of the cervix and

curettement should be done as indicated. A complete hysterectomy is advisable in most cases.

Biopsy

There are several ways of obtaining a biopsy. It is usually taken with a knife; a wedge shaped piece of tissue is excised and should include the growth or suspicious area with some of the normal cervical epithelium. The Burnam biopsy forceps is an excellent instrument for taking biopsies in the office. Bleeding from taking a specimen is usually transient, but if prolonged unduly, can be checked by cauterization or a small pack. Every suspicious area in the cervix should be biopsied. It is a simple easy office procedure, and should be used much more often.

In most advanced cases, tissue taken from any part of the new growth will show cancer on microscopic examination. Even in cases showing obvious carcinoma in the gross, biopsy is important to show the exact type of lesion.

A careful and thorough curettage is the ultimate method in diagnosis of cancer of the endometrium. A small curet that will reach the cornu of the uterus should be used, but with great care. While the so-called "office curettage" may be satisfactory for women with a patulous cervix, the best procedure is thorough scraping of the entire uterine cavity with the patient hospitalized and under anesthesia. Such thorough examination of the uterine cavity may reveal a small well-circumscribed neoplastic lesion, which may easily have been missed by less thorough examination.

The possibility of endometrial carcinoma should be borne in mind in every woman over forty with intermenstrual or postmenopausal bleeding. The one exception to curettage is pyometra. If pus is encountered, the cervical canal is dilated and nothing further done until the infection has subsided; then a thorough curettage is performed.

If you have available a fully competent cytologist who can interpret vaginal smears, this method of diagnosis may be used, particularly as a screening examination in women who come for periodic examinations. The vaginal smear method depends upon the recognition of single malignant cells cast off from the tumor into the vaginal secretion. As stated by Papanicolaou, the smear method should be used as a preliminary or sorting procedure and should be confirmed as a matter of routine by biopsy and tissue diagnosis. There is no doubt that when smears are examined by experts, a very high percentage of correct diagnoses can be made.

Unfortunately, the vaginal smear method has had too much publicity in the public press. It is true that an expertly examined smear might reveal evidence of cancer when no lesion can be seen on inspection, but even then one would not subject the patient to cancer treatment without a positive biopsy. In those cases where a suspicious lesion is found, it is the biopsy and not the smear which is the important procedure. It may not be too long until every well organized hospital or cancer center has a cytologist competent to pass judgment on specimens sent in.

Conclusion

The problem, then, is to educate all women that if they wait for irregular bleeding and unusual vaginal discharge to appear before presenting themselves for a physical examination, they are likely to wait too long. Physicians must include a vaginal examination of every woman as a routine procedure. Simple abnormalities of the cervix such as erosions, ectropion, polyps, lacerations and leukoplakic areas should be eradicated by proper treatment. Patients suffering from cancer must be given prompt and adequate treatment.

The excellent chance of cure in early cancer of the uterus diminishes rapidly with invasion of surrounding tissue. Unfortunately at the present time, over 70 per cent of all cancers of the cervix are in the advanced stages before treatment is started. There is very little hope of permanent cure in such cases, but palliative x-ray and radium treatment may lengthen life expectancy, relieve pain and discomfort, and occasionally cure the patient.

References

1. Cancer Record Registry, Connecticut State Department of Health.
2. Gurskis, Eugenia; Beaver, D. C., and Nelson, H. M.: The microscopic criteria for the diagnosis of early carcinoma of the cervix uteri. Surg., Gynec. & Obst., 85:727-733, (Dec.) 1947.
3. Papanicolaou, G. N., and Trout, H. F.: Diagnostic value of vaginal smears in carcinoma of the uterus. Am. J. Obst. & Gynec., 42:193, 1941.

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The average length of life among the Industrial policyholders of the Metropolitan Life Insurance Company reached a new peak of 66.5 years in 1947. This is one year greater than the corresponding figure for 1946. In the decade since 1937 the average length of life among these insured has increased almost six years, and in the past two decades the gain has amounted to more than ten years. Practically twenty years have been added since 1911-1912, when the average was only 46.6 years.—*Statistical Bulletin*, Metropolitan Life Insurance Company, August 29:5, 1948.

The Climacteric and Its Management

By Howard H. Cummings, M.D.
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THE FUNCTION of reproduction in the human female gradually declines in the latter part of the fourth decade and usually is completely lost in the early part of the fifth decade. During this period of time, menstruation occurs at lengthening intervals and in lessening amounts until it ceases entirely. Accompanying the gradual cessation of menstruation, atrophic changes occur in the external and internal generative organs. These atrophic changes, which are easily demonstrable, markedly affect the ovaries, thereby causing a temporary imbalance of the endocrine glands. The ovaries play the leading role during a woman's reproductive life, assisted by the pituitary gland and possibly the thyroid and adrenal glands. While our knowledge of the part that each gland plays is still incomplete, there is scientific proof that the close inter-relation of the endocrine glands is disturbed when one gland is impaired in its function. In time nature re-establishes a satisfactory endocrine balance.

This critical period in a woman's life—when the power of reproduction is lost and menstruation gradually ceases, when atrophic changes take place in the generative organs and the endocrine glands are thrown into a state of imbalance—is designated as the climacteric. The term *menopause* is frequently used by both physicians and laymen to designate this period of time and change, but scientifically it is not correct. Literally, menopause describes only one prominent objective sign of the climacteric. By usage, however, the two terms have come to be accepted as synonymous.

The multitudinous symptoms experienced by women during the climacteric are difficult to explain on the basis of an endocrine imbalance alone, but when disturbances of the autonomic and peripheral nervous systems are reviewed in relation to endocrine crises, the explanation of the symptoms of the menopause becomes clearer. As a matter of fact, the most prominent symptoms of this period fall into two groups: first, psychic symptoms; second, disturbances of the autonomic and peripheral nervous systems.

Under the heading of psychic disturbances are emotional instability, melancholia, weeping, morbid worrying, insomnia, fatigue, self-depreciation, self-accusation, jealousies, suicidal thoughts, lack of concentration, and impaired memory.

Common symptoms attributed to disturbances of the autonomic and peripheral nerves are hot flashes, chills, attacks of sweating, palpitation, dyspnea, vertigo, headaches, paresthesias, pruritus, and hyperesthesias. These lists are far from complete, but they do enumerate the most frequent symptoms of the menopause.

It would be simple for the physician, when confronted by such an extensive and complicated symptom-complex as the patient relates, to explain all of the disturbances on the basis of menopausal changes. However, during this same period numerous diseases may appear and in their several courses produce all of the symptoms mentioned. The degenerative and metabolic diseases, such as arteriosclerosis and hypertension, cardiac and kidney diseases, diabetes, obesity and anemias, develop during the forties and fifties. Malignancies and benign tumors of the pelvic organs frequently appear. Menstrual disturbances, especially menorrhagia and metrorrhagia, often occur. Thyroid deficiencies or hyperactive states are seen during the climacteric, and neuroses and psychoses can often make their initial appearance or recur at this critical time. These facts make it imperative when women complain of supposedly menopausal symptoms that physicians record complete histories and make thorough examinations.

The medical management of the woman in the climacteric may be very simple, or it may require all of the physician's resourcefulness, skill and judgment. Not all women require medical attention during this period of life. There is a wide variation in the statistics on this important question. Norris estimates that 90 per cent of healthy women go through the climacteric without experiencing any symptoms which interfere with general health or domestic and social activities. A contrary view is expressed by Hawkinson, who estimates that 75 per cent of all women experience

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distressing symptoms during the climacteric. Estimates similar to Hawkinson's in this country range from 65 to 85 per cent. But all statistics dealing with the frequency of disturbing climacteric symptoms are only estimates. No accurate figures are available. Nevertheless, physicians who are consulted by women in this age group know that a large proportion of these have distressing symptoms attributed to the climacteric.

The picture of the menopause is beclouded in the minds of many women by superstitions and old-wives-tales. Among the most common misconceptions are that the sexual life of the woman ceases at the menopause, that her usefulness to her husband and family is largely ended, that numerous and fatal diseases will attack her, and that the climacteric and senescence are synonymous.

Many times the only medical attention required by these patients is a reassuring consultation in which misconceptions are cleared away, and in which the physical changes taking place and causing the syndrome are explained. But this consultation should be delayed until the physician has satisfied himself by a careful history, a thorough physical examination, and all of the clinical tests necessary that disease is not present and causing the symptoms.

Knowledge of psychology and psychiatry is often essential to the successful treatment of patients in the menopause. No group makes more demands upon a physician's time or requires so much reassurance and personal encouragement. In fact, many cases with predominating psychic symptoms need the attention of the psychiatrist. True psychoses appear and self-destruction may occur when women develop mental depression, groundless suspicions and jealousies, lose interest in their normal activities and accuse themselves of uncommitted and unpardonable sins. Patients who develop involutional melancholia—an exaggeration of the menopausal complex—with suicidal tendencies should be treated in institutions by trained psychiatrists.

Most women in the climacteric suffer from relatively mild symptoms. In order of their frequency, Hawkinson lists the symptoms as follows: nervousness, menstrual disturbances, flushes and chills, excitability, fatigue and lassitude, depression, irritability, insomnia, tachycardia, vertigo, decreased memory and concentration, headaches, frigidity, numbness, tingling, and sweating. Fortunately, most of these symptoms may be alleviated or banished entirely by modern hormonal therapy.

Many estrogen preparations are available to the physician today. Most of them are effective. Each practitioner has favorite preparations and methods of administering them. Individual differences in response to drugs make it necessary to try out varying dosages. All of these drugs fall into one of three groups: first, natural estrogens (estrone, estradiol); second, synthetic (diethylstilbestrol, hexestrol, benzestrol); third, chemically modified natural estrogen to increase their effectiveness by slowing down the rate at which they are absorbed. For this purpose natural estrogens are combined with benzoic propionate or palmitic acid. Solid estrogens in pellets and crystalline forms when injected under the skin or into muscle will likewise delay absorption.

Time and experience have served the medical profession well in evaluating newer methods of treatment. This is especially true of estrogenic therapy in the climacteric. Medical opinion today concerning the use of the estrogenic drugs in the management of the menopause is not unanimously in favor of them, but some generally accepted ideas and methods are now well established and extensively followed.

The estrogenic hormones obtained from natural sources are known to be well tolerated by women whether given by the oral, subcutaneous, or topical routes. However, they are expensive and when used for months or, as sometimes happens, for several years, they cause an economic burden on the patient. Yet the synthetic estrogens, though just as effective in producing favorable response, are more irritating and toxic, but because they cost less they are available to all women needing them. Nausea and vomiting, which are the most common ill effects of the synthetic preparations, may be overcome by small doses given with food or upon retiring, or by omitting the drug at intervals, also by sedation accompanying the medication. When the natural or synthetic estrogens are suspended in oily media for hypodermic use and are given by this method, local irritations sometimes occur. Skin sensitizations and general allergic manifestations may also be produced.

In beginning treatment with estrogenic agents, the dosage should be sufficient to alleviate the symptoms or to cause their prompt cessation. Too

small doses will make the patient lose confidence in the efficacy of the drug. Large doses, however, should not be continued; rather they should be reduced as rapidly as possible to a point where the subjective symptoms are held in abeyance. From time to time, for short intervals, the medication may be stopped to test the patient for recurrence of the symptoms. Caution should be used, however, not to stop estrogen treatment suddenly or for too long a period of time. A sudden withdrawal of these drugs will produce uterine bleeding. Overdosage with estrogen may likewise bring about troublesome bleeding. When this occurs in women who have ceased menstruating, the physician is faced with the diagnostic problem of ruling out malignancy of the uterus. Frequently a diagnostic curettage is necessary to answer this question.

No definite plan of estrogen therapy can be given, for each woman reacts in a different way. Most women in the menopause show exacerbation of symptoms in monthly cycles, or at gradually lengthening intervals. Medication may be increased and decreased to meet these cycles. During the early period of treatment it is preferable to have the patient visit her physician for consultation and reassurance. A hypodermic injection of a crystalline preparation may be given at the time of the office visits. In certain cases these treatments may supplement oral administration. The various estrogens, whether natural, synthetic, or chemically combined, which may be taken by mouth make up the most generally used and most valuable drugs for treatment of the climacteric. Once the proper dosage is established, the oral route is most convenient for both patient and doctor. Patients using these drugs, however, should have constant medical direction throughout the whole time of treatment. Physicians should gradually withdraw these drugs and warn their patients not to resume taking them without medical advice.

Are there any contraindications to the use of the estrogens in the climacteric? Women who have malignancies or have had previous treatment for malignant disease should not be given estrogenic therapy. There is one exception to this almost inflexible rule. Older women with advanced malignancies and metastases in the soft parts of the body obtain palliative relief from their suffering by this treatment, but are not cured. Usually cancerous neoplasms are lighted up and their course accelerated by the administration of estrogen preparations. They should never be prescribed until the absence of malignancy has been determined. There is no definite proof that any of the estrogens cause cancer.

Women who have endometriosis or adenomata of the uterus usually improve in health and often become free from symptoms as the climacteric draws to an end. Excessive bleeding and pain, however, may reappear under estrogen therapy.

Thompson believes that women with fibromata of the uterus should not be given estrogens during the menopause as they may cause profuse hemorrhage. Opposed to this view is Karnaky, who advocates the use of large doses of diethylstilbestrol, 25 to 250 mg., injected directly into the anterior wall of the uterus to stop functional bleeding and hemorrhages due to fibroids. He believes that by raising the estrogenic blood level above the estrogenic bleeding level the hemorrhage is checked.

Certain menopausal patients are overstimulated by estrogenic therapy and all of their symptoms exaggerated by it. These women should be treated by other means. Estrogen preparations may cause addiction. It is not unusual to find patients who seemingly cannot do without these drugs and have taken them for a number of years without professional advice. At times they present themselves to physicians because of profuse bleeding brought on by overdosage or sudden withdrawal of the drug. Usually a diagnostic curettage is necessary to rule out malignant changes in the uterus. Following a gradual withdrawal of the drug, substitute therapy must be instituted. Prolongation of the symptom-complex of the climacteric may be caused by unnecessary and too long continued estrogenic therapy. Periods of gradual withdrawal of the drug should therefore be prescribed. If the symptoms disappear or are not troublesome all estrogens should then be stopped.

During the climacteric women who have menstrual disturbances, such as pre-menstrual spotting, menorrhagias and metrorrhagias, present many difficult problems to the attending physician. Treatment of this group is hazardous unless by examinations pelvic pathology is ruled out. Estrogenic therapy often is unsuccessful and radical procedures are necessary. Transfusions of blood, curettage, intra-uterine radium, deep x-ray therapy and hysterectomy are sometimes required to

manage profuse bleeding of the menopause. Certain medicines, however, may be tried, often successfully, before using operative means. Extract of thyroid is especially useful. Well-tolerated doses may be maintained for long periods of time, but while the patient is using this hormone signs of toxicity must be watched for and basal metabolic rates determined.

Androgens are not foreign to the blood stream of women and they may be of great value in treating menstrual complications of the climacteric. The medical profession has been frightened by reports in the literature of masculinizing effects of the male sex hormone. It is true that large doses of these useful androgens will cause hair to grow on the face, a lowering of the voice, atrophy of the breasts, and even enlargement of the clitoris. About 400 mg. of testosterone propionate given in a period of one month will produce masculinizing effects, but rarely is it necessary to give over 250 mg. of the androgens a month in the treatment of menopausal bleeding. Twenty-five mg. of testosterone, given by the hypodermic method three times a week, will lessen bleeding, and 10 mg. of metandren by mouth two or three times a week is sufficient to reduce the blood loss from adenomata and fibromata complicating the climacteric. The androgens find their greatest use in gynecology when patients have had previous malignancies or functional bleeding treated by x-ray, radium or surgery, and estrogens have been contraindicated. Androgens relieve troublesome menopausal symptoms. Hot flashes frequently are checked by the use of these hormones. All masculinizing signs disappear within a few months after discontinuation of the male sex hormone.

A useful group of drugs for the climacteric are the barbiturates. No other treatment is necessary in some cases and when given with the estrogens the dosage of the female hormone may be greatly reduced. Doses of 1/4 gr. of phenobarbital, given one-half hour before meals, and 1 gr. at bedtime, may give complete relief from symptoms.

Many physicians experience great difficulty in weaning menopausal patients away from the estrogen preparations. Christy, in 1945, recommended vitamin E in menopausal therapy in place of estrogen. Personal experience of over two years' duration has confirmed his claims. Women in the

(Continued on Page 1387)

Problems of the General Practitioner in Rural Areas

By J. S. DeTar, M.D.
Milan, Michigan

THE GREATEST problem in rural medical practice today is that of supplying young doctors of medicine to take the places of the older men who are lost by retirement and death. The MSMS is taking all steps to determine that need and to satisfy it.

The Rural Health Survey is being conducted with this specific end in view, and the doctors have contributed $5,000 to start this searching investigation into rural health needs.

The problem is also being attacked by such actions as general practice internships, explanation of general practice by general practitioners in the medical schools. Some schools, notably the University of Wisconsin, have sent their students out to work with rural general practitioners for three months before graduation.

Most rural general practitioners consider that the greatest need in Michigan today is better hospital, x-ray and laboratory facilities in the rural areas. While the Federal Hospital Construction Act will to some extent fill this need, there are many rural areas where the problem will remain for the local residents to solve. It is a problem not only for the doctor but for the residents, because better x-ray, laboratory and hospital facilities enable the modern doctor, both rural and urban, to render better service to the people. Concerted action by local civic groups is far superior to reliance on beautiful blueprints for Federal subsidies with local control; such Federal help always carries with it the possibility of loss of control by community groups.

One of the greatest needs in rural areas is in the field of postgraduate training. The general practice sections of the hospitals and the general practice sections of the state medical societies, with the newly organized American Academy of General Practice, are all tending to return to the general practitioner his rightful place in the American medical plan.

Presented at the Second Annual Michigan Postgraduate Clinical Institute, Detroit, March 12, 1948.

Some Practical Considerations about Endometriosis

By R. L. Haas, M.D.
Ann Arbor, Michigan

ONE OF THE diseases of great interest and importance to all who treat female patients is endometriosis. It is interesting because of the many, as yet, unsolved problems related to it, and important because of its profound influence upon genital function, from the standpoint of menstrual disability and pregnancy.

Much confusion exists regarding the correct terminology to be used when speaking of this disease. One hears of internal and external endometriosis, endometrioma, adenomyoma, adenomyosis, et cetera. Perhaps it is oversimplification to think of it as simply endometriosis, realizing that it may involve any of several structures and be named accordingly. Thus, we have uterine endometriosis, ovarian endometriosis, et cetera. Furthermore, the different varieties of uterine involvement may be designated as the diffuse or circumscribed types, as the case may be. While such a nomenclature may not satisfy the purists, nevertheless it is practical and useful.

The term endometriosis denotes a condition in which endometrium is found growing outside its normal location. One might therefore call it ectopic endometrium. Except for associated features which may occur, this ectopic endometrium is identical with the true uterine endometrium. It is composed of the same glandular elements in a typical stroma, and, moreover, it undergoes the same cyclic variations as does the normal endometrium. It even shows the same decidual reaction during pregnancy. It is, then, obvious that such ectopic endometrium is very definitely affected by the hormonal activity of the ovaries—a point of considerable importance in its management, as we shall discuss later.

It is not necessary to present here an exhaustive list of all the anatomic locations where endometriosis has been found. Suffice it to say, that with rare exceptions, it is confined to the structures of the lower abdomen, including the genitalia, bladder, bowel, peritoneum, rectovaginal septum, and vagina. It is important that, whatever the organ or tissue involved, endometriosis is characteristically associated with adhesions to adjacent structures, adhesions which are dense and usually require cutting rather than blunt separation. Indeed, the latter is fraught with considerable danger, since the density of these adhesions makes rupture of the adherent viscera a very likely occurrence.

Wherever it occurs, endometriosis is characterized by nodules of varying size, usually small, with a typical purple or dark blue color due to the old blood which makes up the contents. Old burned-out implants are represented by patches of blood pigment in adhesions. In the ovary, active implants may grow to considerable size and form the so-called "chocolate cysts" of that organ. It is important to emphasize that all chocolate cysts of the ovary are not endometriosis cysts. Any cyst into which hemorrhage has occurred will be filled with old blood—notably, corpus luteum cysts. Hence, one needs to exercise judgment in treating chocolate cysts. Not all require removal. Next to the ovary the lesions are most commonly found on the posterior surface of the uterus at the level of the internal os, and on the uterine end of the sacrouterine ligaments. As a result of the adhesions associated with these lesions, the colon is often adherent to the uterus in its lower portion, more or less completely obliterating the posterior cul-de-sac.

Implants are also commonly seen on the posterior surface of the broad ligaments, and less often on its anterior surface and the bladder. The other sites described in the literature are uncommon enough that we need not concern ourselves with them here.

The course of the disease is usually one of progression until the climacteric intervenes with its cessation of ovarian function. However, in some instances, the disease apparently becomes inactive for a considerable period of time without obvious explanation. Since endometriosis requires estrogenic stimulation for its maintenance, it follows that regression of the ectopic tissue occurs following the menopause.

One of the unsolved phases of endometriosis is its etiology. The several theories have occasioned a great deal of discussion in the literature, and the papers of Dougal[2] and Counseller[1] will be of value to those interested in the details of these theories. In brief, the theories may be outlined as follows:

1. Endometriosis results from the activation of mullerian duct remains. This theory, of course,

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falls down in cases involving the groin and umbilicus.

2. Endometriosis results from metaplasia of certain tissues which have a common origin with the endometrium from primitive pluripotential coelomic cells. This theory could explain all endometriosis except the very rare ones such as pulmonary or brachial.

3. Endometriosis results from migration of uterine endometrium, either by continuity, implantation, or mestatasis. The latter may be either lymphatic or hematogenous. This migration theory could well explain all recorded sites of the disease.

Although one occasionally discovers asymptomatic endometriosis during laparotomy for other pathologic conditions, most cases are characterized by pain. This may be expressed as dysmenorrhea, acquired and progressive; as dyspareunia; as rectal pain, chiefly during the menses; or as a more or less constant pelvic discomfort. Other symptoms vary, depending upon the organ involved, and among these are bladder irritation or even hematuria, rectal tenesmus or bleeding, and menstrual disturbances.

Examination in a typical case reveals the presence of tender nodulation in the sacro-uterine ligaments and posterior surface of the uterus, which is often retroverted and adherent. There may be tender adnexal masses. Except in rare cases in which the implants involve the vaginal walls, and are therefore visible, one cannot usually be certain of the diagnosis prior to laparotomy.

One of the frequent concomitants of endometriosis is infertility. Whether it is the cause or result of the disease is not always clear. It is suggested by some that the infertility is due to ovarian dysfunction induced by the endometrial implants in the ovary. It is possible that the tubes may be kinked and thus obstructed by the scar tissue and adhesions surrounding implants on the tube or broad ligament, although in most of these individuals tubal patency tests do not show actual obstruction.[4] On the other hand endometriosis does seem to be more common in women who have delayed childbearing until their late thirties than in multiparas of the same age.[3] This might suggest that pregnancy has an inhibiting effect upon endometriosis. Further evidence along this line is to be found in the fact that when pregnancy and endometriosis coexist, the latter is often silent.

The treatment of symptom-producing endometriosis is based upon two principles. Either the stimulation of the lesions by the ovarian activity must be abolished, or the lesions themselves must be destroyed or removed. The former alternative may be accomplished by the administration of testosterone in amounts sufficient to suppress the pituitary and thus the ovary. This form of treatment is being used with increasing success. Symptoms can often be alleviated and an objective improvement in the lesions can sometimes be noted. Testosterone may therefore be used as a diagnostic aid, and indeed its greatest usefulness probably lies here, since its continued use is not only expensive but also precludes the possibility of pregnancy because ovulation is suppressed.

The ovarian stimulation of the lesions may also be abolished by means of castration x-ray or radium and by oophorectomy. However, this form of treatment is generally reserved—for obvious reasons—for those in whom conservative surgical treatment has failed or has been found impossible. It is extremely valuable for those cases with extensive bowel or bladder lesions, since these almost invariably melt away after castration, thus avoiding the necessity for major bowel or bladder surgery.

The second principle of treatment is the destruction or removal of the individual lesions. At the time of operation it is sometimes found that the lesions cannot be removed without sacrificing the reproductive function or without injury to the bowel or bladder. Such lesions can often be destroyed by high frequency fulguration with good result. Conservatism at the time of operation is carried to the extreme in those patients to whom childbearing is very important, even at the risk of being forced to reoperate or later to castrate the few patients whose symptoms persist or recur. It is now a rather generally accepted policy to interrupt certain nerve pathways, the presacral nerves, as a part of conservative surgery when the disease involves the uterus and immediately adjacent structures. This is done in order to render silent any lesions which may have escaped removal or destruction, or which may recur, and reduces the need for subsequent operation or castration.

From the foregoing it is seen that the fundamental consideration underlying our choice of treatment is the preservation of the reproductive function. It should also be emphasized that operation should not be delayed when there is reasonably good evidence of endometriosis, because it is in the early stages of the disease that conservative surgery offers the most. If one waits too long, all chance

of preserving a functional genital tract may be lost. This is not a plea for operation on every painful woman but rather a reminder that endometriosis is generally a progressive disease, and that early diagnosis and operation may therefore be the most conservative course.

In all fairness it should be mentioned that some authors do not feel that such efforts to conserve the reproductive function are justified by the prospects for pregnancy after conservative operation. Counseller,[1] for example, found that among fifty-five patients who had reproduction-conserving operations, only seven subsequently became pregnant, an incidence of 12.7 per cent. However, in a recent survey of patients with endometriosis treated at the University Hospital, it was found possible to preserve the reproductive function in twenty-nine patients. Twelve of these (41.4 per cent) subsequently became pregnant and delivered full term babies at least once.

The picture is not all quite as bright as the above figures might suggest, since one of these patients, after going through one pregnancy and labor perfectly normally, had a considerable amount of pain during her second pregnancy. In the seventh month, acute intestinal obstruction occurred, requiring termination of her pregnancy by section, with resection later of gangrenous bowel. After a very stormy course and a convalescence of several months, she is finally on the way to recovery.

Such a disastrous course during pregnancy after conservative operation is indeed unusual. In fact, no other patient in our group experienced any symptoms which might be attributed to the endometriosis or the operation.

A few of the patients are of special interest.

Case 1.—A twenty-two-year-old single colored girl was first seen because of low abdominal pain, and examination revealed an exquisitively tender left adnexal cystic mass 6 to 7 centimeters in diameter. Since this was the first time the patient had been examined, a conservative course was decided upon. However, signs of pelvic peritonitis shortly appeared, suggesting either a twist of the cyst, or hemorrhage into it. Laparotomy was therefore carried out, revealing a left ovarian endometrial cyst, with extensive endometriosis implants on all the pelvic structures. In addition, there were massive associated adhesions. The cyst was removed and the implants cauterized. The disease appeared so advanced that removal of all of it, or even of both ovaries would be too risky, and it was the operator's opinion that x-ray castration would be required postoperatively. Shortly thereafter the patient married, and four months after operation she conceived. Her pregnancy and labor were entirely uneventful, and now, four years later, she has no symptoms referable to her former disease.

Case 2.—A twenty-three-year-old white nullipara had been observed elsewhere for some time because of sterility and possible endometriosis. Our initial examination confirmed the latter impression, and in addition there was a 6-centimeter cyst of the left ovary. In view of the findings and the marked dysmenorrhea, laparotomy was performed with removal of the chocolate cyst and cautery of the endometriosis implants. She conceived three months later and was delivered elsewhere, and then three years after operation she was delivered here of twins. Both pregnancies and labors were normal, and between pregnancies her menses were no longer painful.

These cases are perfectly characteristic of the results one may expect.

In summary, it may be said that endometriosis is a disease of women in the child-bearing age characterized by the development of ectopic endometrium, chiefly within the pelvis. The disease is usually productive of pain—dysmenorrhea and dyspareunia—and tends to be progressive in most cases. When the diagnosis is reasonably well established (it usually can't be proved until the time of operation), conservative surgery is usually indicated. The value of conserving the reproductive potentiality is to be emphasized. One can expect that at least 40 per cent of patients so treated will subsequently conceive, and their pregnancy and labor will be normal in almost every case.

References

1. Counseller, V. A.: Am. J. Obst. & Gynec., 37:788-797, 1939.
2. Dougal, Daniel: Am. J. Obst. & Gynec., 35:373-386, 1938.
3. Meigs, J. V.: Ann. Surg., 114:866-874, 1941.
4. Sampson, J. A.: Am. J. Obst. & Gynec., 14:422-469, 1927.

LARGE PANCREATIC CYST

(Continued from Page 1355)

42. Pascucci, L. M.: Am. J. Roentgenol., 52:80, 1944.
43. Perse, J. D. A.: Blain Hosp. Bull., 6:12, 1947.
44. Pinkham, R. D.: Surg. Gyn. & Obst., 80:225, 1945.
45. Primrose, C.: Surg. Gyn. & Obst., 34:431, 1922.
46. Rabinovitch, J. and Pines, B.: Arch. Surg., 45:727, 1942.
47. Rienhoff and Lewis: Bull. J. Hopkins Hosp., 54:386, 1934.
48. Santy, P.: Lyon chir., 33:689, 1936.
49. Schmieden, V., and Sebening, W.: Surg. Gyn. & Obst., 46:735, 1928.
50. Shallow, Thos. A. and Wagner, F. B., Jr.: Ann. Surg., 125: 66, 1947.
51. Sheffield, Judson T.: Brit. J. Surg., 30:234, 1943.
52. Soderlund, G.: Acta med. Scand., 170:685, 1946.
53. Thigpen, F. M.: A Pathologic Study of Cysts of the Pancreas. Thesis, University of Minnesota Graduate School, 1940.
54. Walters, Waltman and Cleveland, William H.: Arch. Surg., 42:819, 1941.
55. Wangensteen, Owen H.: Minnesota Med., 20:566, 1937.
56. White, W. H.: Diseases of the pancreas. Guy's Hosp. Rep., 54:17, 1897.
57. Young, Edward L.: New England J. Med., 216:334, 1937.

Detroit Physiological Society

Session of October 21, 1948

Effect of Heat on the Nutritive Value of Lactalbumin

Ruth M. Davis, Paul Rizzo and Arthur H. Smith Department of Physiological Chemistry and Anatomy, Wayne University, College of Medicine, Detroit.

Rations containing all the known essential dietary elements, and differing only in their protein components have been prepared and fed to albino rats. The protein of the diets consisted of lactalbumin, unheated, oven-heated at 120°, 140°, or 200° or autoclaved at 120°, or a mixture of synthetic amino acids, unheated or oven-heated at 140°, or gliadin supplemented with heated and unheated lysine monohydrochloride.

The biological value of lactalbumin decreased progressively as the temperature or the duration of heating was increased. Autoclaving the protein accelerated the production of a decrease in its biological value. Lysine and histidine supplements did not significantly improve the nutritive value of the diets containing heated lactalbumin.

Heating lysine monohydrochloride did not reduce its value as a supplement for gliadin and heating a mixture of the ten essential amino acids did not reduce the biological value of such a mixture.

It appears that the reduction of biological value which results when lactalbumin is heated is due primarily to a decreased digestibility of the protein which results from a change in the peptide and/or grid linkages within the protein molecule.

Alterations in Serum Potassium in Acute Myocardial Infarction

Seymour K. Wilhelm, Department of Internal Medicine, Mount Carmel Mercy Hospital, Detroit, Michigan

Profound biochemical changes have been shown to occur as a consequence of tissue injury. Local tissue injury has been shown by Fox and Baer to cause the involved cells to lose potassium from intracellular fluid and gain sodium and water from extracellular fluid. As a result of this electrolyte shift local tissue edema occurred with a liberation of potassium into the general circulation. It was felt by these investigators that not only did the cells of the injured area respond in such a manner, but that all cells of the body participated in a similar electrolyte shift predisposing the organism for the development of clinical shock. Since myocardial infarction is an example of local tissue trauma, an attempt was made to determine whether a similar electrolyte imbalance would exist in this disease. The serum potassium and sodium was determined in several controls and in ten unselected cases of acute myocardial infarction. Chemical methods were used for these determinations. Values for the controls were found to be within the usual accepted range for normal, serum sodium 310-330 mg./ml., and serum potassium 16-22 mgm./ml. (4.1-5.6 m.eq./liter). Serial electrocardiograms were done in each case and the diagnosis of myocardial infarction was established.

In each case studied an elevation of serum potassium was found in the early stages of infarction. The highest levels recorded were 31.0 mgm./ml. (7.95 m.eq./liter), 33.5 mgm. per cent (8.5 m.eq./liter), and 35.8 mgm. per cent (9.75 m.eq./liter). A decrease in serum sodium was found only in some cases. As the patient improved clinically the K level was found to reach normal. The significance of these findings is yet to be determined. A larger series of cases is in progress.

Rh Anamnestic Reaction and Other Remarks on the Mechanism of Rh Sensitization

Charles L. Schneider, Woman's Hospital, Detroit, Michigan

The anamnestic reaction is a renewed antibody formation, in a previously sensitized individual, without renewed exposure to the specific antigen. Such an anamnestic reaction is known to occur for the Rh antibody during pregnancy. The Rh anamnestic reaction is benign. The Rh factor in the cases thus far encountered was Rh_0. This compares with the pathologic Rh reactions of erythroblastosis fetalis, of which probably 90 per cent are for the factor Rh_0. The Rh_0 anamnestic reaction has developed in a few patients who were delivered in our hospital recently. One of these is presented in some detail to demonstrate its bearing on the mechanism of Rh antibody production.

This mother had been highly sensitized by two

previous pregnancies and four transfusions, three of which had not been typed for the Rh factor. Proof of her sensitization is that her second baby developed erythroblastosis and antibody production. During this pregnancy, her third, her antibody development, ante-partum and post-partum, mimicked that of the cases of most serious prognostic import for the fetus, yet after delivery the baby was found to be normal and Rh negative. The fetus had acquired, passively, a high titer of antibody whose duration was comparable to that of passive immunity of the newborn to infectious disease.

It is suggested that the mechanism of maternal antibody production in such cases may be, to a large extent, the mechanism of the same antibody production in Rh incompatability reactions of erythroblastosis fetalis.

Resolution: E. R. Witwer, M.D.

WHEREAS, Eldwin R. Witwer, M.D., has been a member of The Council of the Michigan State Medical Society representing the 16th District for six years' time; and

WHEREAS, his services have been of such outstanding quality, he having served truly, honestly, justly and without stint or thought of himself, and

WHEREAS, The Council and the Michigan State Medical Society and his colleagues have benefited richly by his wise, fair and cheerful counsel, and

WHEREAS, he has found it necessary to regretfully resign his office on The Council for true, valid and necessary reasons, therefore be it

RESOLVED, That the Michigan State Medical Society through its House of Delegates and The Council herewith tender to Eldwin R. Witwer, M.D., its regrets that circumstances have induced him to do so; and be it further

RESOLVED, That it present him with an illuminated and decorative parchment scroll as a small token of its esteem and appreciation as well as its friendship for the many hours of labor, wisdom and energy he has given so willingly, and be it further

RESOLVED, That the Scroll shall read:

> "This Scroll is presented to Eldwin R. Witwer, M.D., by the Michigan State Medical Society, its House of Delegates and The Council in recognition of his long and faithful service, cheerfully, energetically and wisely performed, with keen and deep appreciation for the efforts and sacrifices he has made to further the ideals, principles and tenets of Medicine, and the Michigan State Medical Society, and to benefit his colleagues and friends.—Presented this 23rd day of September in the year of Our Lord nineteen hundred and forty-eight."

and be it further

RESOLVED, That a copy of this resolution be placed on the pages of the minutes of the Michigan State Medical Society transactions and a copy thereof appear in THE JOURNAL of the Michigan State Medical Society.

Third Annual

MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

Grand Ballroom, Book-Cadillac Hotel, Detroit
March 23-24-25, 1949

Time	Wednesday March 23, 1949	Thursday March 24, 1949	Friday March 25, 1949
A.M. 8:30-9:00	Registration Exhibits Open	Registration Exhibits Open	Registration Exhibits Open
9:00-9:20	Surgery HOWARD K. GRAY Rochester, Minn.	Medicine CHESTER M. JONES Boston	General Practice FRANK W. KONZELMANN Atlantic City, N. J.
9:20-9:40	Gynecology HAROLD C. MACK Detroit	General Practice CARL D. CAMP Ann Arbor	Surgery EDWARD J. O'BRIEN Detroit
9:40-10:00	Pediatrics ERNEST H. WATSON Ann Arbor	Physical Medicine FRANK H. KRUSEN Rochester, Minn.	Gynecology CHARLES S. STEVENSON Detroit
10:00-11:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:00-11:20	Medicine ROBERT C. MOEHLIG Detroit	Anesthesia IVAN B. TAYLOR Detroit	Pediatrics HUGH McCULLOCH St. Louis, Mo.
11:20-11:40	Orthopedics GEORGE T. AITKEN Grand Rapids	Surgery LAWRENCE S. FALLIS Detroit	Urology WILLIAM BROMME Detroit
11:40-12:00	Allergy GEORGE L. WALDBOTT Detroit	Medicine SIBLEY W. HOOBLER Ann Arbor	Public Health ALBERT E. HEUSTIS Lansing
P.M. 12:00-2:00	Luncheon D. W. GORDON MURRAY Toronto, Canada	Luncheon Medical Economics L. HOWARD SCHRIBER Cincinnati, Ohio	Luncheon Sykes Lecture HARRY S. N. GREENE New Haven, Conn.
2:00-2:20	Dermatology HARTHER L. KEIM Detroit	Psychiatry O. R. YODER Ypsilanti	Clinical Pathological Conference (A Medical Case) DONALD H. KAUMP Detroit, Moderator MARK R. McQUIGGAN, Detroit LOUIS J. BAILEY, Detroit
2:20-2:40	Medicine CHAUNCEY C. MAHER Chicago	Pediatrics WILLIAM A. EVANS, JR. Detroit	
2:40-3:00	Otolaryngology JAMES E. CROUSHORE Detroit	Syphilis UDO J. WILE Ann Arbor	Surgery WILLIAM F. RIENHOFF, JR. Baltimore
3:00-4:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
4:00-4:20	Surgery CHARLES S. KENNEDY Detroit	Ophthalmology DON MARSHALL Kalamazoo	Medicine HOWARD F. ROOT Boston, Mass.
4:20-4:40	Clinical X-Ray Conference BEN R. VAN ZWALENBURG Grand Rapids Moderator	Clinical Pathological Conference (A Surgical Case) HAZEL R. PRENTICE Kalamazoo, Moderator MYRTON S. CHAMBERS, Flint HARRY M. BISHOP, Saginaw	Obstetrics WILLARD R. COOKE Galveston, Texas
4:40-5:00	LYNN A. FERGUSON Grand Rapids EDWARD F. DUCEY Grand Rapids		Surgery THOMAS E. JONES Cleveland, Ohio
6:30	Dinner Hour	Dinner Hour	
8:00-10:00	Question Box WM. A. HYLAND Grand Rapids Moderator WYMAN C. C. COLE Detroit ANDRE J. CORTOPASSI Saginaw HOWARD K. GRAY Rochester, Minn. H. MARVIN POLLARD Ann Arbor DONALD M. SCHUITEMA Grand Rapids EUGENE W. SECORD Detroit WALTER A. STRYKER Wyandotte	No Program Thursday Evening	No Registration Fee at the Postgraduate Institute
10:30 p.m.-1:00 a.m.	Dance and entertainment for all registrants and their ladies.		

The Institute will be followed by a one-day
Heart and Rheumatic Fever Day
Book-Cadillac Hotel, Detroit, Saturday, March 26, 1949.

A Christmas Message

This month is dedicated to the hope for peace on earth, good will toward our fellow men.

After two great wars, each of which was to bring world peace, we are now, with the atomic bomb hanging over our heads as the greatest threat to mass annihilation, still apparently no nearer that peace.

In the medical profession, we too have not in the past, nor have we now achieved peace and unity within our ranks. At times, do we not fire unthinking criticism at our colleagues which is destructive to both public esteem for the medical profession and also to mutually co-operative activties on the part of the physicians themselves? A fact we have all noted is the dirty linen of our profession which has been washed and hung on the public line by newspapers and magazines for the laity to view.

The spectre of political medicine has suddenly become more real and is now definitely threatening the medical welfare of our people, our profession, and the American way of life. Just hoping and thinking it won't come to pass is not going to preserve the future of private medicine. Unless we, individually and collectively, make up our minds to and do actually unite within our own ranks, we will continue in the manufacture of an "atomic bomb" of our own which will destroy us as surely as the one used in war.

What are you and I doing as individuals and as groups for our County Medical Society, our State Medical Society, and other medical organizations to promote not only scientific progress but unity of accomplishment in the interest of the medical welfare of our people? It is your and my profession to preserve and work for —not wish for. It can only be done by co-operation and tolerance within our own ranks and by the re-establishment of the conviction that our place on earth is based upon *service to our people.*

May the spirit of Christmas renew for each of us not only an understanding mind, but above all, an understanding heart.

E. F. Sladek, M.D.

President, Michigan State Medical Society

President's

Page

Editorial

HEART MONTH is February, 1949. The American Heart Association has dedicated this month for its fund-raising drive, beginning February 7 and ending February 29, with special accent on *February 14—Heart Day.*

All members of the Michigan State Medical Society are urged to join in Heart Month activities, by bringing to their patients information on heart disease—America's greatest killer, as well as aiding in the fund-raising drive. Greater financial support is needed to curb heart disease in the state.

ECONOMIC MEDICINE—REBATES

THE LAWS OF the State of Michigan prohibit rebates in the practice of medicine.* The medical profession has frowned upon this practice for many years, yet a condition has grown up which has resulted in much criticism of the medical profession, in adverse publicity, and in announcements through the public press of the indictment of optical companies and ophthalmologists throughout the country. We have never condoned this practice. We believe the furnishing of glasses or of orthopedic appliances or the supplying of drugs and medicine is part of the professional service which a doctor renders his patient, and if these material aids to the bettering of health and physical condition of our patients are dispensed in that spirit by the doctor, no criticism can be made. If, however, the doctor sends his patient to the drug store with a prescription, to the orthopedic manufacturer with an order for appliance, or to the optical manufacturer with an order for a pair of glasses, the doctor should not accept a rebate from the dispenser of his orders.

A set of resolutions was brought into the House of Delegates of the Michigan State Medical Society at the meeting in Detroit, covering the phase of the practice of medicine as related to the prescribing of glasses. The House of Delegates adopted a resolution to the effect that the prescribing of glasses cannot be separated from the professional service of the doctor:

"It is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination," and "we urge that the opthalmologists keep within their management the supervision of optical problems, and accept the responsibility involved in the merchandising of glasses to their patients." —Action, House of Delegates, Michigan State Medical Society, September, 1948.

The above action emphasizes the fact that the problem of merchandising of glasses is truly a moral one if the ophthalmologist assumes complete responsibility for the well-being and satisfaction of his patient. Better Business Bureau holds it is of greater moral significance that we allow this part of eye care to be turned over to all kinds of commercial shops dispensing glasses. The action of the Council of the Wayne County Medical Society on September 10, as quoted in the October JOURNAL, page 1050, is superceded by the official governing body of the Michigan State Medical Society. The action of our House of Delegates will certainly stand out as another "first" for Michigan, taking a bold stand in solving a controversial question.

BAD PUBLICITY

THE SUNDAY papers of October 3, 1948, announced that an opthalmologist in Michigan had been indicted and taken into the Federal Courts of Detroit for accepting rebates. This news item is adverse to the good repute of the profession. It was necessary to read the complete text of the article before it appeared that this man was not indicted or charged with accepting rebates; he was charged for failing to report this rebate money in making out his income tax statements. The Government was not complaining about the rebate, but merely wanted its cut! The judge is reported to have instructed the prosecution office to determine whether there was any actual wrong in accepting the rebates as charged in this recent publicity.

Another piece of not-so-good publicity was the announcement in the Sunday papers of October 10 that the ophthalmologists in Michigan had cheated the State out of five million dollars of sales tax which they had not paid on glasses. This article stated that since 1943 the ophthalmologists, in-

*JMSMS, p. 466, (May) 1948.

stead of paying the tax on the whole charge for glasses, had paid only on the wholesale charge from the manufacturer and thus had defrauded the State of at least five million dollars in the past five years, and that the State proposes to get this money back. It was not until October 19, nine days later that the explanation was made from Lansing, in an article on a back page of a newspaper, that the method of paying sales tax which the doctors have followed since 1943 was in keeping with an executive order from the Revenue Department of the State setting up the method of paying this tax; that there was no criticism upon the doctors for this period, and no fraud upon the State; however, another method of collecting this tax will be devised.

Many inquiries have been made by doctors who are prescribing spectacles, asking what to do in this matter of State Sales Tax. We have advised them to continue as in the past until a different arrangement is made by the State.

A BOUQUET

IN THE SUIT the Federal Government has against two of the major optical companies and 2,750 ophthalmologists throughout the nation, the press reported, October 25, that charges had been withdrawn against 204, and fifty-four were dead. Two of these named were from Michigan.

The attorney representing one of the ophthalmologists indicted told the Editor that he had received a marked copy of THE JOURNAL of the Michigan State Medical Society, April, 1948, from the attorneys in charge of the defense of one of these national optical companies, with the statement that the editorial in that issue was the best exposition and suggestion they had seen regarding this whole rebate matter. An attempt is being made to settle the affair through consent decrees. The progress is slow.

We believe the stand taken by the House of Delegates of the Michigan State Medical Society at the annual meeting in Detroit in September is the most outstanding pronouncement that has been made by any medical organization. This resolution will be found in the minutes of the House of Delegates.

THE SHERMAN ACT AGAIN

IT IS BECOMING increasingly evident that the powers in Washington intend to absolutely dominate the practice of medicine. The *Detroit Free Press,* on October 19, 1948, carried the following item:

"WASHINGTON—(AP)—The Justice Department announced an antitrust action against the Oregon State Medical Society and others.

"It charges they have conspired to monopolize prepaid medical care in Oregon and near-by areas.

"Attorney General Tom Clark said a civil suit was filed in the United States District Court at Portland.

* * *

"DEFENDANTS were the Medical Society, the Oregon Physicians' Service, eight county medical societies and eight individual doctors.

"CLARK SAID THE SUIT ACCUSES THEM OF CONSPIRING 'TO DEPRIVE THE PUBLIC OF THE OPPORTUNITY TO ACQUIRE PREPAID MEDICAL-CARE INSURANCE' FROM OTHERS THAN THEMSELVES.

"The complaint, Clark said, also alleges that doctors have been prevented from practicing medicine in Oregon 'on terms of their own choosing and some of them have been denied the use of hospital facilities in Oregon.' "

This means that an antitrust suit has been instituted against the Oregon State Medical Society, the Oregon Physicians' Service, eight County Medical Societies and eight physicians in Oregon, alleging that they are in restraint of the development of prepayment medical care service in Oregon and surrounding states.

We have received a tremendous amount of literature from Oregon giving in detail the actions of the Government and the reaction of the Society. We are amazed at the implications. On page —, we are publishing the allegations as stated in the summons filed in the District of Oregon on October 18, 1948, Civil Act, File No. 4255. If this policy is continued, every medical and hospital service plan in the nation *could* be made defendants in an antitrust suit from Washington. The expense and efforts of defense could be the ruination of the voluntary prepaid medical and hospital care plans.

This action of the Government, taken with election results of November 2 and the announcement of President Truman, as he started back for Washington November 4, that he was going back to Washington to carry out, with the assistance of a favorable Congress, the promises of his campaign, including compulsory health insurance, could mean that the doctors will all be working for the Government within two years under a socialized medicine scheme, probably identical with that now in effect in England. It has been reported that the details of the British plan were worked out and proposed by representatives of the Federal Security Administration in Washington who went to England for that purpose.

Are We Too Late?

The British Medical Association, in a referendum vote, decided not to co-operate, but the power and the pressure of Government were so great that 95 per cent of them are now co-operating. Have we missed the boat? We, in America, have an object lesson before us and two strikes at least against us. The Government has started an anti-trust suit. The President has announced determination to establish socialized medicine. The demand from labor for national health service has been insistent. We have attempted to provide a remedy in our Blue Cross and Blue Shield plans. Last July, General Hawley told us we were now probably too late in supplying the needs of the people. The Blue Cross and Blue Shield Commissions have been, for several years, trying to work out a method of national sales for organizations of national distribution.

A joint meeting was held in Los Angeles in March and April, 1948. A working scheme was drafted, not accepted, but referred to a committee with instructions to perfect it and report back in six months. Soon after the Los Angeles meeting, several states in the West held a meeting to oppose the Blue Cross-Blue Shield contemplated action. In June, the American Medical Association called a meeting of representatives of State Medical Societies to oppose what they called a "Proposed Merger of Blue Cross and Blue Shield." In September, the Blue Cross-Blue Shield Study Committee made a report with a proposed working plan to be considered at a meeting at French Lick Springs, Indiana, on October 24 to 28. It was charged that this report was of limited distribution, but every member of the House of Delegates in Michigan received a copy during the September session. Early in October, the Council on Medical Service and the Board of Trustees of the American Medical Association held a meeting in which they demanded that no consideration or study be given this report until the House of Delegates of the American Medical Association approved the formation of an insurance company. They contended that the Blue Cross and Blue Shield were attempting to take over the practice of medicine. The suit in Oregon ties in closely with the attempts to work out methods of extending Blue Cross and Blue Shield protection. The obstructing action of various organizations, including the Council on Medical Service of the American Medical Association, has again delayed a progressive move in the voluntary, non-profit medical and health service programs. At French Lick Springs, there was nothing that could be done, but pass the whole matter on to the House of Delegates of the American Medical Association. It is fitting, however, that the final responsibility rest with the AMA, if as a result of dallying and indecision and inaction, the medical profession loses its independence and becomes merely a pawn of the politicians in Washington.

W. S. JONES, COUNCILOR

W. S. JONES, M.D., of Menominee, Michigan, eye, ear, nose and throat specialist, and a very active member in the affairs of the Menominee County Medical Society, was elected to The Council for the Thirteenth District to replace Dr. W. H. Huron who was not a candidate for re-election.

Dr. Jones was born in Jeffersonville, Georgia, June 8, 1890. He was graduated with the A.B. degree at the University of Georgia, in 1911, and the M.D. degree, University of Chicago, in 1915. He served as intern in the Presbyterian Hospital and Children's Memorial Hospital, Chicago, then conducted a general practice in Arizona from 1916 to 1922. After completing a postgraduate course in nose and throat at the University of Pennsylvania and a course in the eye at Knapp's Memorial Hospital in New York and the University of Vienna, he located in Menominee in 1923. He holds the Certificate of the American Academy of Ophthalmology and Otolaryngology. He was a former president and secretary of the Menominee County Medical Society and is now on the staff of St. Joseph's Hospital, Menominee, Michigan, and Marinette General Hospital, Marinette, Wisconsin. He is married and has three children—one son, who is a doctor of medicine, and two daughters.

Dr. Jones comes to The Council as an experienced worker in Medical Society affairs.

YOU—PROFESSOR!

WHEN A PHYSICIAN has been approved by the State Medical Board and granted his license, he feels that now, at long last, he can begin "living" to make up for his years of low in-

come and long hours while he acquired his education and hospital training. It is a privilege, not only financial, to practice medicine. However, he shortly learns that his new job entails numerous responsibilities which he did not see before he entered practice.

He must take his turn serving the county medical society in office and on committees. He must attend hospital meetings. Certain social service organizations that are closely allied to his work require his advice. The community expects him to co-operate, often by giving free physical examinations, in various health enterprises. All of these services he gives freely. But there is a new obligation arising which many doctors have shunned: the education of the public.

Doctors of medicine, following the ethics of the profession, have felt that speaking or writing for the public is a form of self-advertising. Now the demands for speakers on health practices at parent gatherings, for service clubs, schools, and other groups is so great that there are hardly enough medical men available. When M.D.s are not to be found, these social-welfare audiences will listen to less-informed speakers who may not have our profession's viewpoint concerning public health, preventive medicine, and modern therapy.

Have you been impatient with the writers for popular magazines who have told too dramatically of recent medical discoveries? Has your patient asked why you do not use this anesthesia, that miracle drug, or t'other all-inclusive one-shot preventive? What have you done about the annoyance? Perhaps you have written angrily to the magazine, but that does not recall the printed word. Furthermore, the editors will continue publishing health articles because the public loves 'em and they help to sell their journal.

There is little to do about it except to write those popular articles yourself. There are dozens of self-help magazines on the news stands of which you have never heard perhaps. But they are being read by the thousands. The editors are clamoring for health articles by "authorities." Why leave the medical education of the public to reporters and professional writers who often have prejudices or the tendency to overdramatize?

You may have a vague unrest concerning writing for popular consumption because one sometimes is offered remuneration. Dr. Morris Fishbein has no such compunctions (see *The Saturday Evening Post*). Anyhow, what you earn from medical writing can easily be spent on additional hospital equipment you have wished for, so that worry is over!

We talk considerably about the pitfalls of socialized medicine. We are trying to educate the public to our way of thinking. How about educating the public to our way of doing? Our way of practicing medicine? Modern educational psychology admonishes to begin teaching at that point where an interest already exists. Well, patients are interested in themselves; and in us only as we affect their lives. We can obtain an understanding public by simple, straightforward discussions of our materials and methods of treatment.

From here on, it's up to YOU, Professor!

STANLEY T. LOWE, M.D.

ON THE RUN . . . .

Spinal-cord symptoms appearing in the patient with pernicious anemia constitute a medical emergency.

* * *

Neuroblastoma is the most common neoplasm of the abdominal cavity in early childhood.

* * *

Thyroid compression of the esophagus occurs when the gland is fibrous, hard and invasive or when it is situated substernally.

* * *

While 40 per cent of cases of myeloma have normal serum protein levels, 99 per cent show an elevation of the serum globulin.

Selected by W. S. REVENO, M.D.

THE CLIMATERIC AND ITS MANAGEMENT

(Continued from Page 1376)

menopause are effectively relieved of vasomotor instability. There are no stimulating effects and it does not cause changes in the genital organs or the breast. It is well tolerated and has no bad side effects. It may be that the beneficial effects of vitamin E are purely psychological. Perhaps this is just a placebo. However, when ephynal acetate in 10 mg. doses is given three times daily, many menopausal patients are entirely relieved of their disturbing symptoms.

After a period of months or years, women in the menopause gradually realize that their peculiar and troublesome ailments have disappeared. They feel unusually well. Ambition returns and they take their active places again in the home circle and in society. If free from organic disease, they can look forward to many more years of usefulness and happiness. The gratitude of these women is a source of professional satisfaction to physicians who have patiently and skillfully led them through this trying time.

PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES—1948

Table of Contents

*Pages 1257-1284 appear in the November 1948 issue; Pages 1290-1410 in the December 1948 issue.

MICHIGAN STATE MEDICAL SOCIETY

Eighty-third Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

(Continued from the November issue)

Third Meeting

Tuesday Morning, September 21, 1948

The meeting convened at ten-twenty o'clock, J. S. DeTar, M.D., The Speaker, presiding.

THE SPEAKER: The meeting will come to order.

Is Dr. O'Meara here? May we have the report of the Committee on Credentials?

J. J. O'MEARA, M.D. (Jackson): Mr. Speaker, I have in my hand the names of the credentials from the members who are delegates to this Society, to the number of 76, which is more than 40 per cent of the necessary requirement for a quorum, 50 per cent of which are not from any individual county.

If it is agreeable, this will be accepted as a roll call.

Is there any unfinished business to come before the House?

Are there any new resolutions? This is the last meeting at which resolutions may be presented.

If not, we will proceed to supplemental reports of the Reference Committees. Many of the Reference Committees were unable to finish their work yesterday, and their reports are to be rendered.

Is there a supplemental report of the Reference Committee on Officers' Reports?

Is there a supplemental report of the Reference Committee on Reports of The Council?

XII—b. ON REPORTS OF THE COUNCIL

C. L. WESTON, M.D. (Shiawassee): There is, Mr. Speaker.

THE SPEAKER: Dr. Weston.

C. L. WESTON, M.D. (Shiawassee): Mr. Speaker and Members of the House: The report of The Council as contained in the Handbook was considered by the Committee last evening and reported back. Our report today deals with the supplemental report of The Council.

Item 1 of the Supplemental Report deals with membership. There is no further comment on that,

Item 2, on Finances. There is no further comment at this time.

3. Public Education Account. No further comment.

4. Information to the public. The Committee approves this statement. The Committee believes that the money spent for public relations is wasted unless each and every doctor does his share toward good public relations in his daily contacts with the public.

5. Professional Relations. The Reference Committee recommends the adoption of this policy.

The Committee believes that the over-crowding of patients in public institutions is a public relations problem and that the Michigan State Medical Society should take an active part in promoting better institutional care. We refer especially to state mental hospitals.

6. Michigan Medical Service. No comment was felt necessary.

7. Michigan Hospital Service. No further comment.

8. Second Michigan Rural Health Conference. This was also disposed of yesterday.

9. Full-time co-ordinator for Rheumatic Fever Centers. The Committee commends the action taken in securing a full-time medical co-ordinator for the Rheumatic Fever Centers.

10. Michigan Heart Association. There is no further comment, above the report of The Council on that.

11. Beaumont Memorial on Mackinac Island. The Committee approves of this project.

12. Proposed Veterans Administration Hospital in Ann Arbor. This subject was taken care of in a resolution which was passed last evening by the House of Delegates.

13. New Home for Michigan State Medical Society. The Committee recommends further study on the question of a permanent home for the Michigan State Medical Society and suggests a lease for the time being, rather than a purchase.

In regard to the Recommendations of The Council on page 54 of your Handbook, if you will please refer to the first recommendation of The Council, the Committee approves this recommendation.

Recommendation No. 2. The Committee approves of this recommendation.

Recommendation No. 3. The Committee approves of Organization Seminars and urges that each and every component society be contacted by State Society officers in an effort to assist the component society in setting up and conducting proper meetings.

Recommendation No. 4, in regard to the dues. There is no comment on this recommendation at this time. There will be a recommendation on the resolution concerning dues at the end of this report.

In the matter of the Statement of Policy by The Council, on page 55 of the Handbook, a Statement of Policy re Immunization, the Committee endorses this Statement of Policy. The Committee recommends further that a stronger emphasis be placed on immunization by the family physician rather than by Public Health employees.

Statement of Policy re Venereal Disease Control. No comment.

Statement of Policy re Making Cancer a Reportable Disease. The Reference Committee approves the Policy of The Council.

Statement of Policy re Rheumatic Fever Control. (Page 56 of Handbook) The Reference Committee agrees with this Statement of Policy and recommends that wherever possible this general policy be extended to similar health campaigns.

Statement of Policy re Community Health Centers. The Committee approves of this Statement of Policy.

Statement of Policy on Rh Testing by State Health Department (page 57). The Committee approves this Statement of Policy.

Mr. Speaker, the Committee recommends the adoption of the Report of The Council as a whole, and I so move.

(R. H. Baker, M.D., Vice Speaker, took the chair.)

THE VICE SPEAKER: You have heard the report of the Reference Committee on Reports of The Council. Is there a second to the motion?

E. G. KRIEG, M.D. (Wayne): I second the motion.

THE VICE SPEAKER: Is there any discussion?

If not, all in favor say "aye"; opposed. Carried.

C. L. WESTON, M.D. (Shiawassee): In regard to Recommendation No. 4 of The Council, we mentioned in our report that a resolution introduced yesterday by Wayne County will take care of that situation.

XII—b. SPECIAL ASSESSMENT ($25.00)

"WHEREAS, The need of additional funds for various purposes in the work of the Michigan State Medical Society is apparent; and

"WHEREAS, This need is not static but varies from year to year; and

"WHEREAS, An increase in dues will be of a more permanent nature while a special assessment must be voted each year according to the specific needs; therefore be it

"RESOLVED, That instead of a raise in the dues of the State Medical Society the special assessment of $25.00 be continued for the current year."

The Reference Committee unanimously recommends adoption of this resolution, and I so move.

THE VICE SPEAKER: You have heard the motion of the Reference Committee. Is it seconded?

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE VICE SPEAKER: Is there any discussion?

All in favor say "aye"; opposed. The motion is carried.

C. L. WESTON, M.D. (Shiawassee): Mr. Speaker, the Committee recommends the acceptance of the report as a whole, including the final resolution, and I so move.

THE VICE SPEAKER: Is there a second?

M. A. DARLING, M.D. (Wayne): I second the motion.

THE VICE SPEAKER: Any discussion? All in favor say "aye"; opposed, "no." It is carried.

Now we have the Report of the Reference Committee on Standing Committees. Is there anything on that?

E. G. KRIEG, M.D. (Wayne): No report.

THE VICE SPEAKER: Is there any report by the Reference Committee on Special Committees?

G. C. STUCKY, M.D. (Eaton): No report.

THE VICE SPEAKER: The next item is the Report of the Reference Committee on Constitution and By-laws. Dr. Spalding.

XII—g. ON CONSTITUTION AND BY-LAWS

(The revised Constitution and By-laws will be published in the January, 1949 Number of JMSMS—Editor.)

E. D. SPALDING, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: The enormous amount of work Dr. Gruber has done on this Constitution and By-laws revision can only be appreciated by those who have actually tried to recheck the thing with him. I am sure that with the work that Dr. Gruber has done and with the work the committees and various officers have done on this at this time, there are no basic changes. It is merely the question of rewriting it and, as Dr. Gruber so properly stated yesterday, taking the By-laws out of the Constitution and clarifying some of the verbiage at certain confused points. There is no fundamental change in principle.

If you will bear with me as we go along, I am quite sure that this can be accomplished without a great deal of time. In other words, to save reading this entire document of twenty-odd pages, those Constitution and By-laws changes as proposed, which you had handed to you in mimeographed copies yesterday, I will not actually read, but read by title, with a few words of ex-

planation where necessary, and will only read those organizations where an actual change has taken place.

Of course, it is perfectly proper, as each chapter and section comes up—whether the committee has recommended a change or not, anyone from the floor who wishes to make a change has that privilege. Otherwise, if it meets with your consent, without objection, we will pass on without actually reading the unchanged parts.

One more point. There is no essential difference in these few changes that are going to be discussed this morning, between the work of Dr. Gruber and the final form gone over by the Committee. This again is just a question of polishing up certain corners and changing some verbiage. Also your Speaker and I see eye to eye on these things, so I wish you would feel that those people who spent time on this thing have no serious conflict in their ideas. I think that will give you a little assurance as to the acceptance of some of this, without unnecessary debate.

Thirdly, I wish to make one important parliamentary point. It is very essential, when you are not revising a part of the Constitution but when you are rewriting all of the Constitution and By-laws, that you do not find yourselves in the middle of the procedure without a Constitution. Until the last vote is taken, you are operating under the Constitution and By-laws as published in the back of this green book, your old and present Constitution. The parliamentary maneuver that we are about to cross is that I will move the acceptance of the proposed revision to the Constitution as presented to you in your vote, by Dr. Gruber, and the By-laws as presented to you yesterday in mimeographed form. I will move the adoption of these two documents, with the additional changes to be listed this morning. We will then vote any further changes, as we go over them this morning, as amendments to that resolution. The amendments will be passed, changed, or voted down, as you wish, as amendments to the fundamental motion. After the thing is amended to suit you, then we will pass the motion for the adoption of the Constitution and By-laws as a whole, and the thing immediately goes into effect.

Do I make this point clear? I don't want any of you to think that something is being put across.

It is quite acceptable. In fact, Dr. Gruber and Dr. DeTar and Dr. Baker and I discussed this thing in detail, and I assure you that it is kosher.

Without more preamble, if you will consult the mimeographed sheets that were handed to you yesterday, there was one resolution and one petition which were referred to the Committee on Change of By-laws, which have definite bearing in this Constitutional revision. As to the resolution, when we come to that portion of the By-laws to which it applies, I will give you the opinion of the Committee on this resolution, and we will pause a moment, and you can vote the resolution in or out, as presented on the floor, and then we will go on, incorporating your decision in the revision of the By-laws.

The other was a petition from Wayne County for additional Councilor representation. In view of the fact that the By-laws specifically provide for such, in case you wish it, now or at any other time, no constitutional or By-laws revision is necessary to accomplish this, and in order not to confuse the issue, I will not bring this petition up until we settle the Constitution and By-laws revisions as a whole, and then we will do as you like about the petition, which I will bring up afterwards.

Now on the mimeographed sheet, first taking up the Constitution and then the By-laws, Mr. Speaker, I move that the proposed revision to the Constitution, as presented a year ago by Dr. Gruber, and the proposed revision to the By-laws as presented yesterday, be adopted, with the recommendations and changes hereinafter to be listed.

(J. S. DeTar, M.D., The Speaker, took the chair.)

The Speaker: You have heard the motion. Is there a second?

W. S. Reveno, M.D. (Wayne): I second the motion.

The Speaker: The motion has been made and seconded. Now is there any discussion?

E. D. Spalding, M.D. (Wayne): The discussion of this, of course, consists of the changes we are about to list.

Taking up the Constitution first, there are only four changes, and only one of them is of any importance.

In Section 1 of Article I, "The name of *the* organization" should be "The name of *this* organization."

I move the adoption of this change.

The Speaker: The motion is that in Section 1 of Article I, of the new Constitution—you will not find this in your Handbooks but this is in the mimeographed copy handed to you yesterday—the word "the" be changed to "this organization."

Is this amendment supported?

R. A. Springer, M.D. (St. Joseph): I support it.

The Speaker: Is there any discussion?

If not, all in favor of passing this proposed amendment say "aye"; opposed. The motion is passed.

E. D. Spalding, M.D. (Wayne): Secondly, still in the Constitution, Article X, entitled "Council," the mimeographed copy states: "The Council shall be the Executive Body of The Society."

It is important at this point to put in a clear definition of just what The Council consists, and following that introductory sentence, this insert is to be placed in Article X, Section 1, after the introductory sentence, and it shall then read:

"The Council shall be the Executive Body of The Society. It shall consist of one councilor from each Councilor District, the president, president-elect, immediate past president, speaker of the House of Delegates, with the secretary and the treasurer, the last two being elected by the foregoing."

Then go on as the mimeographed copy shows.

I move the adoption of this change.

The Speaker: You have heard the motion. Is there a second?

S. L. Loupee, M.D. (Cass): I second it.

The Speaker: Is there any discussion on the addition of these words in Article X after the first sentence?

If not, all in favor say "aye;" opposed, "no." The motion is passed.

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I should like to propose a change in Article III, Section 3. Where it says "and thus to better equip," for proper verbiage it should be "thus better to equip."

I move that be changed.

The Speaker: Dr. Gruber proposes a change on page 1 of the Constitution, Article III, Section 3, to change the wording to read "thus better to equip." Is that right?

Is there a second to that motion?

R. L. Wade, M.D. [Branch]: I second it.

The Speaker: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." It is carried.

E. D. Spalding, M.D. (Wayne): For the information of Dr. Reveno, who is serving as my prompter, in case I slip, there is a minor change in Section 2 of Article X about the immediate past presidents, that we are not bringing up.

This closes the necessary changes in the proposed new Constitution, and we will pass on to the By-laws.

S. L. Loupee, M.D. (Cass): Before we close the discussion of the Constitution, I read Section 1 of Article III and it sems to me that it should be changed a very little bit, the verbiage. It reads now:

"Purposes. To bring into one organization the Doctors of Medicine of This State of Michigan, and through it and other State Societies to form and maintain The American Medical Association."

I wrote in here "and through it and similar Societies of other states to form and maintain The American Medical Association." It makes it a little clearer.

The Speaker: Dr. Loupee, would you be willing to propose in the form of an amendment, that that wording be changed?

S. L. Loupee, M.D. (Cass): I know this is a very precious subject, and that these men have worked hard on it and done a wonderful job. I don't like to offer any change whatsoever which might interfere with their ideas and their construction. If they agree to that change, it seems to me it would help.

The Speaker: Dr. Loupee, we have held many meetings of this Committee and at every meeting we have many changes. So I am sure they are not sensitive. If you would like to propose the amendment, I will put it to a vote.

S. L. Loupee, M.D. (Cass): I propose that in line 2 of Section 1, the words "and similar Societies of other states" be inserted.

The Speaker: Then that would read: and through it and other similar Societies of other states."

S. L. Loupee, M.D. (Cass): That is right.

T. K. Gruber, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

I might say, gentlemen, that this Committee has been far from perfect, as Dr. Gruber will admit, and if anyone sees any suggestion for a change that we can put in the Constitution that we may have missed, please bring it up while we are voting.

Dr. Spalding.

E. D. Spalding, M.D. (Wayne): That closes the amendments to the proposed change in the Constitution, unless there is further comment from the floor.

We will now pass on to the By-laws. As you all know, a revision of the Constitution requires a two-thirds vote, but a revision of the amendments to the Constitution, while they are still in the form of amendments, only requires a majority vote. The By-laws will only require a majority vote.

In Chapter 1 of the By-laws, Section 2, a small change in line 3. It reads:

"The House of Delegates is empowered to revoke the charter of any Component County Society whenever it finds that such Society has materially breached any of the provisions of the Constitution *and*"—it should be changed—"*or* By-laws of This State Society"—not "Constitution *and* By-Laws."

This is a minor change. If there is no objection, shall we pass on?

The Speaker: Is there any objection expressed?

If not, we will accept it.

E. D. Spalding, M.D. (Wayne): These very minor changes, unless you wish to object, I think can be handled without actual vote.

Coming to Chapter 5, Section 5, Member Emeritus, it now reads:

"Member Emeritus—Any Doctor of Medicine who has been in the practice of medicine for fifty years, and who has maintained a membership in good standing for twenty-five consecutive years, may, upon his application and recommendation of his Component County Society, be elected a Member Emeritus—"

The proposed changes are two and very small. It has been thought that many people do not wish to come forward and apply for this. In other words, if the State Society recommended this thing, that was sufficient. On the other hand, there are other men who, although their County Society would gladly recommend such a thing, would prefer to remain as active members. That point is also to be considered.

The Committee thought that that could be gotten around by changing this to read as follows: "who has maintained a membership in good standing for twenty-five consecutive years, may,"— leave out the words "upon his application and"—"*upon* recommendation of his Component County Society, *with his consent* be elected a Member Emeritus."

I propose these two changes, the deletion of "upon his application and" and the insertion of "with his consent" as I have read it.

I so move.

The Speaker: You have heard this motion concerning the provisions for the election of Members Emeritus. Is there a second to that motion?

C. S. CLARKE, M.D. (Jackson): I second the motion.

THE SPEAKER: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." It is passed.

E. D. SPALDING, M.D. (Wayne): We now come to Section 10, an added section. The last section in Chapter 5 in the mimeographed copy is Section 9.

The new Section 10 of Chapter 5 will read as follows:

"Any change in membership status shall be effected by resolution presented in triplicate before the annual meeting of the House of Delegates after previous certification by the county and state secretaries."

This is to relieve Dr. Foster of the constant need of repeating his requests that these things be put in proper order, and it is so stated here, specifically so, so that everybody will know exactly what is required. It is no essential change, but merely eliminating the procedure.

I so move.

THE SPEAKER: You have heard the motion. Is that seconded?

W. S. REVENO, M.D. (Wayne): I second it.

THE CHAIRMAN: Is there any discussion?

E. D. SPALDING, M.D. (Wayne): I might ask if that is satisfactory to Dr. Foster.

THE SPEAKER: Is there any suggestion by Dr. Foster?

SECRETARY FOSTER: Does the wording say "the county and state secretaries"? Shouldn't it read "secretaries of the county society and state society"? It could almost sound like the Secretary of State.

THE SPEAKER: Would that be agreeable in the last line, to change that to "the secretaries of the county and state societies"?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I move the acceptance of the amendment.

THE SPEAKER: Dr. Gruber moves an amendment to the proposed amendment, to the effect that the wording be changed to read, "after previous certification by the secretaries of the county and state societies." Is there any discussion on Dr. Gruber's amendment? Is it supported?

E. G. KRIEG, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion on the proposed amendment to this amendment? If not, all in favor say "aye"; opposed, "no." The amendment to the amendment is passed.

Is there any discussion on the amendment proposed by Dr. Spalding, to the effect that this additional section be added to Chapter 5? Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. SPALDING, M.D. (Wayne): Chapter 6 of the By-laws has to do with the discipline of membership, in a large number of sections. There is no change suggested until we come to Section 9. The verbiage here, as you have it on the mimeographed form, is a little confusing.

Section 10 and Section 12 should follow one another consecutively, and Section 11 should be placed at the end, allowing Sections 10 and 12 to follow each other directly. So the first proposed change is to renumber Section 12 as Section 11, and put Section 11 at the foot and label it Section 12. That is merely clerical and needs no vote unless somebody objects.

Now the confusion arising between Section 10 and what is now the section below it, Section 11, labeled Section 12 on your copy. If the first sentence in Section 12, as labeled in your copy, is deleted and put into Section 10, it will be clearer. I will read it as it would be changed, if it has your approval.

Section 10 will now read—deleting the first six words—"No order shall become effective until"—and starting the sentence at that point:

> "The affected member shall have an opportunity to avail himself of his rights of *further* appeal according to the following procedure: Appeal to The Council of this State Medical Society; appeal to the House of Delegates of this State Medical Society; and final appeal to the Judicial Council of the American Medical Association. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by a component County Society Council may appeal to his Component County Society."

A word of explanation. The purpose of this is as follows. In those small county societies where the society acts for itself, this does not come up, but in Wayne, where we have over 2,000 members, such an organization is totally unwieldy and such action is taken by the council representing the society. The council of Wayne County has 20-odd members in itself. There is one other county society and possibly two where they have a council. This provision is to make it perfectly clear in the records as to what is the procedure, whether there is a council or whether there is not. We feel that the first action on the recommendations of the Ethics Committee in the smaller societies could be by the society itself, but in the big societies with the council the recommendations of the Ethics Committee go to the council and the council takes such disciplinary action as it sees fit.

However, we cannot deprive a member of the right to appeal to the society as a whole if he wishes such adverse publicity.

Therefore, this is merely to put definitely into the record what such rights are.

May I read this once again as corrected?

> "Section 10. The affected member shall have an opportunity to avail himself of his rights of further appeal according to the following procedure: Appeal to The Council of this State Medical Society; appeal to the House of Delegates of this State Medical Society; and final appeal to the Judicial Council of the American Medical Association. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by a component County Society Council may appeal to his Component County Society."

In view of the fact that this and the next section really go together, may I ask that they be acted upon together?

Passing on from Section 10, as I have outlined it, to the next contiguous section, labeled No. 12 on your list but now labeled No. 11, you will delete the first two lines and reverse the order of the following sentence, so that the three words at the end of the third line shall come first in the sentence, and the section will now read—We have taken care of the first sentence, "A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by his Component County Society, may appeal therefrom to The Council of The Michigan State Medical Society," in the section I have just outlined and deleted it from this section. Now this Section 11 will read:

> "Notice of appeal to The Council of The Michigan State Medical Society shall be in writing and set forth"—and go on just as it is listed.

It is merely taking one sentence out of the second section and incorporating it in the first for clarity. This is a little confused. Do you wish it read again? Shall I read the two together?

DELEGATES: No.

E. D. SPALDING, M.D. (Wayne): I think I will. It is an important point. It will now read.

(Dr. Spalding reread the amendment.)

Now one more statement. Going back one to Section 9, the one on the Ethics Committee, there is an insert, and I will read: "The Ethics Committee may reprimand or counsel a member; however, discipline must be meted out by The Society as a Whole *or its Council.*" That is an insert. "A two-thirds vote of the members present of the Component County Society *or its Council,* due notice having been given, is necessary for expulsion or suspension of a member."

Then you go on as I have outlined.

I moved the adoption of these changes, if they are not too complicated.

THE SPEAKER: The motion is for the adoption of the changes in Sections 9, 10, 11 and 12 of Chapter 6 as read. Is there a support?

W. S. REVENO, M.D. (Wayne): I support it.

THE SPEAKER: Is there any further discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. SPALDING, M.D. (Wayne): Carrying on now, Chapter 7, under the heading of General Sessions.

Chapter 7. The General Sessions is unchanged.

Chapter 8, House of Delegates, at the top of the page. Section 1 has been clarified as follows: The last line has been taken up and put ahead of the second sentence. The thing that is being transposed and put up ahead is:

"Reports having been properly filed with The Secretary of This State Society"—then go on with the second sentence:

> "Reports having been properly filed with the Secretary of this Society, each Component County Society shall be entitled to send to The House of Delegates each year one delegate for each fifty members and one delegate for each additional major fraction thereof. Any Component County Society"—

and now delete the unnecessary words "which holds a charter from This State Society" and put in "having" instead of "has" so it reads:

> "Any Component County Society having less than fifty members shall be entitled to send one delegate."

I will now read it without interruption.

Section 1 of Chapter VIII, Composition. "The House of Delegates shall be composed of Members elected by The Component County Societies. Reports having been properly filed with the Secretary of this Society, each Component County Society shall be entitled to send to The House of Delegates each year one delegate for each fifty members and one delegate for each additional major fraction thereof. Any Component County Society having less than fifty members shall be entitled to send one delegate."

I move the adoption of Section 1 as amended.

THE SPEAKER: Will you read the last sentence again?

E. D. SPALDING, M.D. (Wayne): The last sentence will read: "Any Component County Society having less than fifty members shall be entitled to send one delegate."

THE SPEAKER: You have heard the proposed amendment. Is there any support?

J. J. LIGHTBODY, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion?

J. J. LIGHTBODY, M.D. (Wayne): I wonder if that means active members? Does that take in all classifications of members?

THE SPEAKER: The question is whether that takes in all classifications of members. Can you clarify that, Dr. Spalding?

E. D. SPALDING, M.D. (Wayne): I assume that is so. The verbiage is the old Constitution. Can the Secretary correct us on that?

THE SPEAKER: Dr. Foster says that the old Constitution has referred to all classifications having a vote. I wonder whether that should be clarified in the new Constitution, whether the question will come up again.

E. D. SPALDING, M.D. (Wayne): How did you determine, Dr. Foster, whether a society was entitled to one, two or more delegates?

THE SECRETARY: The allocation of delegates to the House of Delegates at the present time is based wholly on all of the members, of any classification whatsoever, voting or otherwise. In other words, if the county society has 76 members, and in that group there are all categories—retired, emeritus and so on—they are all calculated in the determination of how many delegates they have at the present time.

E. D. SPALDING, M.D. (Wayne): Mr. Chairman, that has now been the procedure for all time. I don't think it should be changed.

THE SPEAKER: Is it understood by the delegate who asked the question that if the wording remains the same all members will be included, including life members, honorary members, and all

members? Is that the meaning, Dr. Gruber, that your Committee intended to put into this wording?

T. K. GRUBER, M.D. (Wayne): Yes.

THE SPEAKER: That has been the custom in the past. Is there any question or any objection to the present wording, which obviously would include all members of the Society at all times?

There is no objection. Is there any discussion on the motion to adopt this amendment?

If not, all in favor say "aye"; opposed, "no." The motion passed.

E. D. SPALDING, M.D. (Wayne): We now come to a point on which there may be a great diversity of opinion, and it is a very simple and direct point. The verbiage is not at all complicated. Do you want one or two regular meetings of this House of Delegates a year? The Committee has no opinion on this. If you want to leave the Constitution as it is, you have one regular annual session of the House of Delegates at the time of the annual meeting of the Society.

THE SPEAKER: Pardon me, Dr. Spalding, but before you get involved in the next subject, I would like to bring up one point which Dr. Foster has been discussing since we made our last vote. According to our decision, all members who are on the roster of any County Medical Society will be included in computing the number of delegates privileged to come to the House of Delegates. That will include active members and life members and membrs emeritus and honorary members, and also associate members, if we make no distinciton.

There are some societies, particularly Wayne County and Washtenaw County, which may have 15 or 20 or 30 or 40 or 100 internes as associate members. I raise the question to the House, before we go on, whether we care to eliminate the associate members from the category of members in the Society, which determines the number of delegates we may have. I bring the question before the House.

T. K. GRUBER, M.D. (Wayne): We do not include any but voting members in our report to the Secretary, in computing the number of members that we have in the Wayne County Medical Society. Associate members and nonvoting members are not included.

THE SPEAKER: Dr. Gruber says that Wayne County does not include any but voting members. According to the wording we agreed on a few moments ago, any members may be included.

R. L. NOVY, M.D. (Wayne): At the suggestion of Dr. Luce, I call your attention to the fact that if you exclude a lot of those your representation in AMA will be cut down proportionately.

THE SPEAKER: Dr. Novy, you mean if we exclude—

R. L. NOVY, M.D. (Wayne): Those various categories you have mentioned who have been closely allied and have an interest in your medical societies may be excluded in your representation and your representation in AMA will be proportionately cut.

THE SPEAKER: If we exclude associate members, in other words, from the list of members it will determine the number of delegates we may have in this House of Delegates. Is that what you mean?

R. L. NOVY, M.D. (Wayne): Not in this House of Delegates, but in the AMA delegation quota.

THE SPEAKER: You have heard the point.

Dr. Gruber!

T. K. GRUBER, M.D. (Wayne): Dr. Foster, do you include associate members in your report for our quota in the AMA?

THE SPEAKER: Dr. Foster!

SECRETARY FOSTER: As a matter of fact, there are only about two societies in the state where we do not include them. The point I was making to Dr. Spalding is that the people who are included in this calculation are those classifications of membership which include men who had at some time or other enjoyed active membership and who, through some honorary contribution by this House have been put in these special categories. Associate members in some societies have never been members. They have been interns and residents and folks who have not been members. The calculation in the office for our allocation of delegations is based on those categories containing men who have at some time been active members, like Emeritus, Retired, Honorary, and so on, where they have been active members but through the various provisions of the Constitution have been given these honors, but not those who have never been members or who are laymen or who are just put in like the associate membership.

Of the 55 county societies there are only one or two who have any associate membership, and they are not figured in our calculation—just the categories that were predicated originally on active membership.

E. D. SPALDING, M.D. (Wayne): Lest you feel that Wayne County is taking an unfair advantage, the number of associate members in Wayne is not great if you take into consideration the fact that we have over 2,000 members. It is a drop in the bucket.

I think it complicates things a little bit to make this distinction. I grant Dr. Foster's point, that it should be limited to those who have at some time had an active part, but if I may be pardoned, I should like to refer to a time-honored story about two young ladies to whom the comment was made, "You girls aren't ladies of the evening," and they said, "Why, nosuh, we ain't, but we hopes to be." These general interns hope to be members, and I think it would be all right to consider them as such.

I assure you that Wayne will get no advantage with 2,000 members as a whole. It will be a drop in the bucket.

THE SPEAKER: Before we leave the subject, I would like to ask if the House is satisfied with the present wording, as adopted in our last motion—if there is no objection, if there is no limit.

R. J. ARMSTRONG, M.D. (Kalamazoo): I would like to know if there is anything in this proposed group of By-laws that specifies this matter. It seems uncertain whom you are going to include in counting.

THE SPEAKER: I wonder if Dr. Spalding will read the final wording, which indicates which members will be used to determine the number of delegates.

E. D. SPALDING, M.D. (Wayne): The By-laws do not specify, to the best of my knowledge, anything on that, and simply refer to members. I think if you will leave it unqualified, you will benefit yourself in the AMA and you will not prejudice yourselves here.

THE SPEAKER: Is there any further discussion?

If the House is satisfied, we will proceed to the next paragraph. Dr. Spalding.

E. D. SPALDING, M.D. (Wayne): As you recall, Dr. Gruber brought this point up before the previous objection, and the thing we have been discussing for the moment, which we will now resume, is: Do you want two or one session a year? The Committee is quiet on this thing.

In Section 4 it says: "The House of Delegates shall meet annually at the time and place of the meeting of This State Society as a Whole, as when it meets in General Session, and may hold such number of meetings as The House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meetings."

If you wish, you can put in the additional sentence: "It shall also hold a session between annual sessions at a time and place to be fixed by The Council of the Society."

The reason you are delegating the fixing of the time of your meeting to The Council is that you cannot meet if you cannot find a place to meet, and if you think that this House of Delegates can find a place to meet at the drop of a hat, try it. The Council will have a hard enough time, as a small body, to determine where physical facilities are available and what the time shall be for such special meeting within two or three weeks. That is why it is allocated to The Council, if you so wish.

On the other hand, if you wish to continue with one meeting a year, with the understanding that a special meeting can always be called, this does not need to be placed in.

For the sake of making it specific, the Committee suggests that this additional sentence be put in at the end of Section 4:

"It shall also hold a session between annual sessions at a time and place to be fixed by The Council of the Society."

If it is your pleasure to have but one meeting, one regular meeting a year, that will simply not be included.

I move this insertion as an amendment.

THE SPEAKER: You have heard the motion. Is it supported?

C. L. WESTON, M.D. (Shiawassee): I support it.

THE SPEAKER: Now I wonder if we all realize the full import of this proposed amendment. Those of you who have your copies, this is Chapter 8, Section 4. May I read it again? It reads:

"It"—that is the House of Delegates—"shall also hold a session between annual sessions at a time and place to be fixed by The Council of the Society."

Is there any discussion on this amendment?

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, I think I might be a little more explicit, if instead of voting this amendment for the moment, we simply voted the question: Do you want two regular meetings a year? Then we can discuss the verbiage later. I want this point perfectly clear.

Therefore, if I may, the motion that I will put to the Chair will be that we continue with one meeting a year. Vote it down, if you want to. Then we will go on with the other.

THE SPEAKER: The Chair will recognize this motion, that the House of Delegates continue to have one regular meeting per year.

Is there a second to that?

D. C. BLOEMENDAAL, M.D. (Ottawa): I second it.

THE SPEAKER: Is there any discussion on whether the House of Delegates shall have one meeting or two?

L. W. GERSTNER, M.D. (Kalamazoo): It is largely personal, but it seems to me that the cost of such a meeting must be quite high, and certainly the aggregate cost of coming to such a meeting for an entire delegation also must be exceptionally high. I believe that from the economical angle, a second meeting is not practical.

I also feel that if a single meeting will accomplish the same result in the great majority of cases, we might better have one annual meeting, and even though it is a job to find a place for a special meeting, we may rarely need such meeting.

I would like to see but one meeting a year.

THE SPEAKER: Is there any other discussion on the motion? The motion is that we shall have one regular meeting a year.

R. H. DENHAM, M.D. (Kent): May we not insert the privilege of having a second meeting if it is deemed advisable by The Council?

THE SPEAKER: That question I should like to refer to Dr. Spalding. I should like to ask Dr. Spalding whether it would appear later in the Constitution that The Council may call a special meeting of the House of Delegates at any time.

E. D. SPALDING, M.D. (Wayne): It is perfectly possible to call a special meeting at any time it seems advisable or there is urgent need.

THE SPEAKER: That is in The Council.

E. D. SPALDING, M.D. (Wayne): Whether it is or it is not, the question is: Do you want two regular meetings or one regular meeting?

THE SPEAKER: The motion is that we shall continue to have one regular meeting per year. Is there any further discussion?

S. L. LOUPEE, M.D. (Cass): I think now is the time to express our opinions.

THE SPEAKER: Yes.

S. L. LOUPEE, M.D. (Cass): I am in favor of one meeting.

THE SPEAKER: Is there any further discussion?

If not, all in favor of the motion that we continue to have one

regular meeting of the House of Delegates per year say "aye"; opposed, "no." The motion is passed.

Dr. Spalding, will you read your—

E. D. SPALDING, M.D. (Wayne): That obviates the necessity of making this change. It was simply introduced to give you a vehicle to express the contrary idea if that was your view. So there will be no change there.

That won't ball up the works, will it, Dr. Reveno? Just drop out that one sentence.

Now Section 6, which is a little different type of thing. We are still under the House of Delegates, Section 6, It became complicated as to whether a delegate elected at one meeting but failing to sit, and his alternate was put in his place, would be the delegate if you had a second meeting. If you are not having any second meeting, no change need be made in Section 6. So the suggested change there to take care of that will simply also be eliminated.

As the thing now reads, and you have a special meeting—

> "A Delegate once seated shall remain a Delegate throughout the entire session and for one year thereafter until the next Session of This House of Delegates."

In other words, if an alternate once takes the place of a regular delegate, if there is a special meeting that alternate sits until the second meeting. That is the way your Constitution now is, and unless you are having another regular meeting, I think it would be best to leave it just as it is.

So the Committee recommends no change, unless somebody wishes to make some change in Section 6 at this time. Otherwise it will stand as it is.

Still under Chapter 8, House of Delegates, going on to Section 10 under Alternate Delegates and then a variety of subsections and so on, you come down to page 8, to subsection (j).

The Committee feels that as it is given in the mimeographed sheet there are a large number—14 to be exact—of committees specified, and then other committees if you wish. These are regular committees. This is a little burdensome, and the suggested change is that subsection (j) read not "It *shall* have the following reference committees," but "It *may* have the following reference committees, together with Tellers and Sergeant at Arms," and so on.

I move the change of the word "shall" to "may." "It *may* have the following reference committees."

THE SPEAKER: You have heard the motion. Is there a support?

W. S. REVENO, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." Motion carried.

E. D. SPALDING, M.D. (Wayne): Passing on to Chapter 9, Council third line, it specifies here: "It shall hold an Annual Meeting in January of each year—" That is inadvisable. There are times when that should not be, and if the words "in January of each year" are deleted, it will read:

"The Council is the Executive Body of this State Society. It shall determine its own time and place of meeting. It shall hold an Annual Meeting at which time it shall elect to serve one year its Chairman," and so on.

That merely eliminates the necessity of placing that meeting in January, which might not be convenient.

I move the deletion of the five words—in January of each year.

THE SPEAKER: You have heard the motion. Is it seconded?

R. W. TEED, M.D. (Washtenaw): I second it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. SPALDING, M.D. (Wayne): The same applies to Chapter 9, Section 7, in which—

> "The Council shall elect an Editor of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, and a Treasurer at its annual meeting *in January of each year.*"

If the first goes out, the second goes out automatically and it needs no vote.

We are almost through gentlemen.

Under Chapter 10, Standing Committees, Section 3—"Committee on Preventive Medicine shall consist of its Chairman, The State Health Commissioner, and Chairmen of the following Committees—"

and there is a long list given. There is inserted here a committee that does not appear before, namely the Committee on Diabetes. It has not seemed to the Committee necessary that this be inserted. The section goes on to state "Such other Committees as may, from time to time, be appointed to study and develop programs dealing with specific diseases." At the present time it was not felt necessary to complicate the list by adding the Committee on Diabetes.

This is not in your present Constitution, so one amendment is to delete the name of the Committee on Diabetes, as printed in your mimeographed sheet.

The Committee on Heart and Degenerative Diseases, which appears above that, has been with us for a considerable time. On the other hand, you now have a very active Rheumatic Fever Control Committee, which takes care of heart disease in the other group. Now the question comes up, Why specify heart and degenerative diseases? The Committee moves that that be changed to the Committee on Geriatrics, which makes a more general occupation.

Therefore, the proposed change is the change in the name of the Committee on Heart and Degenerative Diseases to Committee on Geriatrics, and the elimination of the Committee on Diabetes. Any of these can be inserted, if necessary.

I so move.

THE SPEAKER: You have heard the motion. Is there a second?

E. G. KRIEG, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion on the motion to eliminate the Committee on Heart and Degenerative Diseases and the Committee on Geriatrics and eliminate the Committee on Diabetes?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. SPALDING, M.D. (Wayne): We now come to Chapter 11, Officers. There is one small change in Section 9. This will probably appear to you like counting the angels dancing on a pin, but it is an important parliamentary point. It is right in the constitution, and the man who put this in originally didn't know his constitution at all. When you elect a man to preside over your House, you do not deprive him of his franchise to vote. That is absolutely fundamental.

Now the fact that the presiding officer usually does not vote is simply because the vote usually isn't necessary, but if the vote is by ballot, the presiding officer in any meeting always votes at the time the ballots are collected, and not later, so in case there was a tie, his vote would have been registered. That is always so.

In Section 9, speaking of the Speaker of the House of Delegates, it says he shall preside at sessions, do this, that and the other thing, and it goes on and says: "He shall have a right to vote only when his vote shall be the deciding vote." That is totally unnecessary. It is confusing. As some of you may not know, not only may a presiding officer vote to break a tie, but he can vote to make a tie, and therefore defeat a motion. There is only one motion in the book which can be determined by a tie vote, and that is a motion to support a parliamentary decision of the Chair. All other motions require a majority vote, with one exception. We won't go into that.

Therefore, in view of the fact that your Speaker, according to parliamentary procedures, has the right not only to break but to make a tie and therefore defeat the motion, don't complicate the situation by the insertion of this statement. Parliamentary rules are perfectly specific out of this book. This is merely confusing.

The Committee moves that in Section 9 the sentence be deleted: "He shall have a right to vote only when his vote shall be the deciding vote."

I so move.

THE SPEAKER: Is this motion supported?

T. K. GRUBER, M.D. (Wayne): Second the motion.

THE SPEAKER: You have heard the motion. It has been supported. Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. SPALDING, M.D. (Wayne): Two more points.

Chapter 12 deals with the referendum. To the best of my knowledge, extending back over some twenty years in this House, we don't have referendums, but it is here in case.

In the first place, Section 1, under Referendum, Chapter 12, deals with this problem. The General Session of your Society has a right, by a two-thirds vote, under your Constitution, to take unto itself a decision which is before the House. The Society can take such a decision away from you by a two-thirds vote and decide it themselves. That Section 1 we are not changing.

Section 2 is the reverse. In case a very important point is up before the House of Delegates, a very moot point, and they do not feel that they have been sufficiently instructed by their representatives as to how they should vote, they can refer it back to a General Session and let the General Session vote.

Now the machinery of accomplishment of this is a little clumsy. Remember, those of you who are upstate, if the emergency should arise and the weather was bad, it might be that you would find yourself represented by Wayne, and that would be a terrible thing.

Therefore, it is the feeling of the Committee that it would be much better in such case of an important matter, that the House of Delegates felt they were unable to go there, that this should not be by any haphazard meeting in the middle of the winter, when it was difficult to get here or there, but this vote should be taken by the constituent county societies, and vote on the question certified, the vote of each county society certified by its secretary and sent to the Secretary of the State Society, in case such a matter was referred to the Society as a whole by the House of Delegates.

If this is your pleasure, it can be accomplished by changing Section 2 to read as follows:

> "The House of Delegates, by a majority vote"—

crossing out the words "of its members" which is not necessary—

> "may submit any question pertinent to the community and organized medicine to the membership of The Society for its vote"—

Delete the next three lines, which are quite garbled English, and insert the following:

> "Such vote to be taken by County Societies and certified by their secretaries to the Secretary of the State Society. Two-thirds of the vote cast shall be required to carry the question."

It probably never will arise, but if so, for heaven's sake have a piece of machinery that is usable.

I recommend the adoption of this change.

T. K. GRUBER, M.D. (Wayne): I second the motion.

THE SPEAKER: It has been seconded by Dr. Gruber. Is there any discussion?

S. L. LOUPEE, M.D. (Cass): As I listen to the able presentation of this matter, I can see yet that you are not quite clear in specifying whether this final vote should be by counties or by the membership of each county society. I presume you mean by the membership of each county society, but it might be that each county was voting as a unit. Which do you mean?

THE SPEAKER: Dr. Spalding.

E. D. SPALDING, M.D. (Wayne): It is their verbiage. Wayne has always been accused of voting as a unit. I would suggest that some of you attend our caucuses. If you can get unity in Wayne, you can be President of the United States.

I think the verbiage is plain—"Such vote to be taken by County Societies." Of what do the county societies consist unless it is of their members, and nothing is said as to whether they vote as a bloc or anything else. That is up to them to decide. They can report their vote by societies certified by their secretaries. If you wish to change it, do so.

S. L. Loupee, M.D. (Cass): Mr. Speaker, Dr. Spalding has failed entirely to get my point.

E. D. Spalding, M.D. (Wayne): I am sorry.

S. L. Loupee, M.D. (Cass): I don't expect absolute unity in one society. That wouldn't be democracy. What I propose is that you should be specific as to how this vote is to be recorded, whether it is to be such-and-such a county votes "yes" or "no"—that the vote be by counties or counting the individual votes.

E. D. Spalding, M.D. (Wayne): It is the same problem evidently as when we vote for the President of the United States. We vote by states. I get your point. It is a good one I think.

W. S. Reveno, M.D. (Wayne): I think the section is quite clear. In the first place, this chapter deals with the referendum and, secondly, Section 2 begins with this clarifying statement: "The House of Delegates, by a majority vote, may submit any question pertinent to the community and organized medicine to the membership of The Society for its vote."

That is a vote of the membership of the entire Society and is arrived at by appealing to the various County Societies to poll the vote from the individual members.

The Speaker: Then go on. "Two-thirds of the vote cast shall carry the question." In other words, two-thirds of the vote cast by the members of the State Society. Is that right?

Is there any further discussion? Are there any amendments proposed? If not, the motion on the floor is to adopt the revision of Chapter 12, Section 2, and we will put it to a vote. All in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): I think when the two sentences of Section 2 are taken in conjunction the point is clear. Thank you for bringing it up. I think it is a good point.

I will pause one moment and call your attention to one of the mixed verbiage things in here. It says "provided further that two-thirds majority of the members." Will somebody on the floor kindly tell me what a two-thirds majority is, a majority being more than half? That is just a comment on the side.

Finally, one of the minor points in Chapter 16, Section 1:

"At The Annual Meeting of each Component County Society or at a designated meeting of which ample notice has been given, each Component County Society shall elect"

and the text says "Delegates or Alternates." It is a typographical error and it should be "Delegates and Alternates." I just call it to your attention. It is not necessary to vote on that unless somebody objects.

Now, Mr. Speaker, we now get to the point where, having amended the proposed changes, both to the Constitution and By-laws to your satisfaction, the question now before the House is to vote on the question of the adoption of the Constitution and By-laws.

The Speaker: The motion has been made to adopt the Constitution as presented to this Society a year ago, which was held over for one year, with minor alterations as delineated by the Chairman of the Reference Committee on Constituition and By-laws and also the By-laws as amended today.

Is there any further discussion on this motion?

L. C. Harvie, M.D. (Saginaw): I think we should have a little more clarification as to how the delegates will be tabulated for this House.

As in the Constitution now, that has been read, in order to elect delegates a County Society shall have 50 members for each delegate or a fraction thereof. Some clarification should be made as to active members. As was stated a while ago, the associates could be tabulated. As a member of the special committee, we just certified 30 on associate memberships from Washtenaw. Those members are not active, and that would entitle Washtenaw to an extra delegate. It seems to me some clarification should be made.

The Speaker: Dr. Harvie refers to Chapter 8, Section 1. I think we should ask the Chairman of the Reference Committee to read again the phrase which we adopted tentatively as an amendment. I have it right here.

E. D. Spalding, M.D. (Wayne): Section 1 as amended this afternoon reads:

"Section 1. House of Delegates. Composition. The House of Delegates shall be composed of members elected by the component County Societies. Reports having been properly filed with the Secretary of this Society, each component County Society shall be entitled to send to The House of Delegates each year one delegate for each fifty members"—unqualified—"and one delegate for each additional major fraction thereof. Any component County Society having less than fifty members shall be entitled to send one delegate."

W. W. Babcock, M.D. (Wayne): I would like to point out that some societies have associate members that are laymen and also that some county societies have nonresident members. I agree with Dr. Harvie that the members who come as delegates, for delegates, should be specified. I might suggest that the words "active, life and emeritus"—I believe those are the three groups—be inserted so that there will be no question.

The Speaker: You are making that suggestion. It is possible for any member on the floor to move, in order to get this taken care of, that some action be taken to change the wording in Section 1, Chapter 8.

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I move the reconsideration of that motion to adopt this Section 1.

The Speaker: Dr. Gruber, you are moving reconsideration of the amendment which was passed concerning Chapter 8, Section 1?

T. K. Gruber, M.D. (Wayne): Yes.

The Speaker: Is there a second to that motion?

C. S. Clarke, M.D. (Jackson): I second it.

The Speaker: All in favor of reconsidering Chapter 8, Section 1 say "aye"; opposed, "no." The motion is passed.

The question before the House now is as to the wording or rewording of Chapter 8, Section 1.

W. S. Reveno, M.D. (Wayne): I have one suggestion which may eliminate the questions that have been raised, particularly with regard to the possibility of including nonprofessional members, and the suggestion is simply that we insert the words, between where it says "for each fifty members"—"for each fifty *professional* members." That would include all varieties of membership, with the exception of the associate members that are not in the profession or have not been included and granted a vote in the County Society.

The Speaker: You have heard the suggestion that the word "professional" be inserted before "members."

E. D. Spalding, M.D. (Wayne): What is the profession, may I inquire?

The Speaker: Whose profession?

T. K. Gruber, M.D. (Wayne): I propose to amend this in lines 1, 2, 3, 4—"The House of Delegates each year one delegate for each fifty *voting* members and one delegate for each additional major fraction thereof."

Voice: Support it.

The Speaker: The motion is to amend Chapter 8, Section 1 to the effect that the word "voting" be put between the words "fifty" and "members" so that the section shall read: "each year one delegate for each fifty voting members and one delegate for each additional major fraction thereof."

Is there any discussion on this motion?

R. J. Armstrong, M.D. (Kalamazoo): Will someone kindly tell us exactly who the voting members are?

The Speaker: Dr. Foster, will you elucidate on who the voting members of the Society are?

Secretary Foster: It is specified in the Constitution, and it says, for instance, that the retired members do not have a vote. It would seem rather unfair to eliminate from your consideration men to whom you have given retired membership. We have many instances throughout the State where men who are on that list attend medical meetings religiously. They are always present. They just aren't practicing, but they want to keep the contact, and they are just as valuable to those societies, particularly the smaller groups, as the members who are in active practice. They have been in active practice but probably for some disability or something of that kind, they have been forced to accept retired membership, and had they been in long enough, they would have emeritus memberships with the same contribution—but still they have no vote.

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I will insert "retired and voting members," with the consent of my second.

Voice: Agreed.

The Speaker: The word "retired" has been included with the word "voting" and the consent has been given by the delegate who seconded the motion. Now it reads: to insert the words "voting and retired" in the section.

T. P. Wickliffe, M.D. (Houghton-Baraga-Keweenaw): I am a freshman at this medical meeting, and I have enjoyed it very much—the House of Delegates meeting. I enjoyed the way in which Wayne County takes care of us and carries on. They are doing a good job for us.

I can see no reason why this great body of delegates should object to an associate member being represented. I am sure they couldn't do any harm to the proceedings of the House of Delegates. I see no reason to change this by law. There will never be more than one or two delegates represented as associate members, and if they are interested enough to be associate members of our Society, I think they should be represented in our House of Delegates without any injury or influence on what we might do.

R. W. Teed, M.D. (Washtenaw): Mr. Chairman and Members of the House: The first sentence in Section 1 reads:

"The House of Delegates shall be composed of Members elected by The Component County Societies."

All of these members that are elected to membership in the component county societies have been elected because they came under the rules governing such election. Consequently, if the County Society feels that these men warrant election, they should have representation, and certainly that applies equally to interns who will at some time undoubtedly be members of the Society and therefore need representation.

It is a question of taxation without representation. If we are going to elect them to membership, we should allow them representation.

The Speaker: Before I grant the floor to Dr. Bailey, who asked for it, I would like for Dr. Spalding to list for us the implications of this wording—who would be included under "voting and retired" according to the new Constitution.

E. D. Spalding, M.D. (Wayne): This is also according to the old Constitution, because it hasn't been changed.

Chapter 5. Membership and Classification of Membership. This has been inserted in different places, but the gist is exactly the same.

All Active Members have a vote, of course.

Honorary Members shall be without the right to vote.

Associate Members shall have no right to vote.

Retired Members shall have no right to vote.

Members Emeritus shall have all the benefits and privileges of membership.

A Nonresident Member shall not have the right to vote.

A Life Member has the right to vote.

Summarizing this, Active Members, Emeritus and Life Members have the right to vote, but Associate Members and Honorary Members do not.

The Speaker: Dr. Bailey asked for the floor. Do you care for the floor, Dr. Bailey?

As it now stands, it will be Active Members, Emeritus Members, Life Members and Retired Members.

L. J. Bailey, M.D. (Wayne): I disagree with those, including Dr. Foster, who feels that others than these voting members should be allowed representation on this floor. They do not have repre-

sentation in their component societies. Therefore, I see no reason for giving them representation here.

Dr. Foster stated earlier in this discussion that members mentioned in the Constitution who were allowed representation in the House of Delegates were voting members. I see no reason for changing that sentiment.

THE SPEAKER: Any other discussion?

T. K. GRUBER, M.D. (Wayne): I think if we allow the Associate Members, Wayne would have quite an advantage. I think probably Washtenaw would have quite an advantage. There are a lot of them that aren't in residence in Wayne County—several hundred of them. I see no reason why nonvoting members or nondues-paying members, in the Associate Membership class, should be used to swell your number of Delegates. Wayne has not practiced that. We have not reported our Associate Members, and that general type of membership, in computing the number of members that are from Wayne County to determine the number of delegates. I think it would be an unfair advantage.

I certainly hope that this motion passes.

THE SPEAKER: Any further discussion?

R. A. SPRINGER, M.D. (St. Joseph): It seems to me that we are eliminating a lot of men from rendering service to our Society by taking away their right to vote and hold office.

For instance, under Associate Members, in the Handbook, as the Constitution now stands, you have a category of Active Members, and it says: "by transfer, for the period of time they are temporarily out of active practice on account of protracted illness." They don't have the right to vote or hold office.

There are a lot of men who have a protracted illness that are not bedridden, and have the time to carry on the business of this organization or of their county organization, and it seems to me that it is unfair to them, and to the retired members perhaps, to prevent them from voting and holding office. There are many times when that individual, as I have said, has time to do things that the man in active practice hasn't the time to do. I think that before we go on, we should give some consideration to those two particular types of memberships.

THE SPEAKER: Is there any further discussion on this question?

PRESIDENT LEDWIDGE: Certainly Associate Members should have no place in the vote. In the first place, they haven't been in there long enough to know what is going on. Many of them are temporary members and will never become permanent members of our Society. In the second place, if the Retired Member wants to be active, he should not retire. It is not compulsory.

THE SPEAKER: As the motion stands now, it is that Voting and Retired Members be considered. That is Active, Emeritus, Life and Retired. Is there any further discussion? Are you ready? If you vote "yes" you will vote for giving recognition in determining the number of delegates to Active Members, Emeritus Members, Life Members and Retired Members.

If there is no further discussion, all in favor of this proposed amendment to Chapter 8, Section 1, say "aye"; opposed, "no." The motion is passed. Therefore, Chapter 8, Section 1 stands as amended.

Now the question before the House is whether the Constitution as published a year ago, with minor changes this year, and the By-laws as amended today, shall be adopted. Is there any further discussion on the main motion?

If not, all in favor say "aye"; opposed, "no." The motion is passed by more than two-thirds vote.

Dr. Spalding, do you have any further report from your Committee?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker—

THE SPEAKER: Do you have a point of order, Dr. Gruber?

T. K. GRUBER, M.D. (Wayne): No. I would like the privilege of the floor for a minute.

THE SPEAKER: You may have the privilege of the floor.

T. K. GRUBER, M.D. (Wayne): A man had an automobile he wanted to sell for $100. He couldn't sell it. A salesman came along and said, "I will sell it." He told him what a great car it was. He was going to sell it for him at $500. The man decided, "I had better keep it myself."

The things that have been said about me, I should keep to myself.

I just want to say that I didn't do this revision. This was a committee composed of Dr. Foster, Dr. Ledwidge, Dr. Holmes and Dr. DeTar and Mr. Herbert, our General Counsel. We had many meetings, and much correspondence, and the meetings lasted until long hours. I want them to have recognition for the good work that they did and for the zest and effort they put into this thing in trying, we will say, to streamline our Constitution and By-laws and bring them up to date.

I just want to thank the Committee. I want to say I did very little of the work. I sat quietly and said "yes." They made the suggestions.

THE SPEAKER: Gentlemen, on behalf of the Committee, I should like to say that we did work hard all right, but the Constitution had to be written by some one person, and that one person was Tommy Gruber. He did the major portion of the work, and it was a terrific job.

While we are at it, I should like to throw a few bouquets at Dr. Spalding and his Committee. They worked hard and did a very good job. On his Committee were Dr. Allen of Bay City, Dr. Day of Jonesville, Dr. Kane of Muskegon, Dr. Reveno of Detroit, and Dr. Strong of Ontonagon. They did an excellent job.

Dr. Spalding, do you have further business to present?

DR. SPALDING (Wayne): Another matter is a petition, not a resolution, which was introduced by Dr. Babcock of Wayne. It is very short. I will read it to you.

XII—g. CREATION OF 17th & 18th COUNCILOR DISTRICTS

"PETITION

"Under the present organization of the Councilor Districts in the Michigan State Medical Society, Wayne County with 43 delegates out of the total of 118 (or 36 per cent of delegates) comprises the First and Sixteenth Districts, and therefore has only two Councilors out of the total of sixteen (or 12½ per cent of the Councilors). Therefore, the Wayne County Medical Society hereby petitions the House of Delegates of the Michigan State Medical Society to subdivide the present First District into the First and Seventeenth, and the present Sixteenth District into the Sixteenth and Eighteenth, each with a Councilor of its own. This will make a total of four Councilors for Wayne County out of a new total of 18 (or 22.2 per cent of the Councilors), representing 36 per cent of the delegates."

The ratio as it now stands in your body, one per cent of the councilors represents three per cent of the delegates in Wayne, but one per cent of the councilors represents one per cent of the delegates in most of the places. This would only bring Wayne up to 1½ per cent instead of one per cent.

This is the petition and the reason for it. The Committee feels that this is a matter to be decided by the House and the Committee itself has no recommendations.

THE SPEAKER: What is your motion as to the disposition of this resolution? You move what?

E. D. SPALDING, M.D. (Wayne): The Committee has no recommendation, but to bring it before you, I move the granting of this petition.

THE SPEAKER: The granting or acceptance of this petition has been moved.

H. W. WILEY, M.D. (Ingham): I second the motion.

THE SPEAKER: Is there any discussion?

Passage of this would be approval of the petition or resolution. Is there any discussion?

L. W. GERSTNER, M.D. (Kalamazoo): I would like the opinion of The Council in regard to this petition.

THE SPEAKER: Would you like to call on any member of The Council?

L. W. GERSTNER, M.D. (Kalamazoo): I wish that one of the Councilors would volunteer.

THE SPEAKER: May we have an expression of opinion from one of the Councilors?

C. E. UMPHREY, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: I think probably this suggestion originally came from me. I am Councilor from the First District, as you know and during the course of business in Wayne I know that some of you know that our Council meets every two weeks. There is a vast amount of business going through the hopper. We have about fifty committees there, and occasionally The Council would encounter new business or something that had been done by the State Society and would turn to the Councilor and say, "What happened?"

This happened a couple of times last year, and I happened not to be on the Executive Committee and was unable to give them the information. They feel that if they have a little greater representation and solidify, this information perhaps would be forthcoming, inasmuch as they carry a seat on the Wayne County Council.

That is the major thing. They want to co-operate. They want to make their work conform with the work of Wayne and the measures that have been passed by the State Society. They want to be influenced and controlled by what the State Society does. It will save some embarrassing moments.

I am very much in favor of this, as a Councilor, and I think that the representation as here denoted will be much more in keeping with the membership of Wayne.

THE SPEAKER: Is there any further discussion on the resolution?

If not, all in favor say "aye"; opposed, "no." The Chair will ask for a rising vote. All in favor will please rise. Will you please be seated? All opposed to this resolution will please rise. It is obvious that this resolution is passed.

Dr. Spalding, do you have further business to bring before the House?

PROPOSED REDUCTION IN TERM OF COUNCILORS

E. D. SPALDING, M.D. (Wayne): There is one more thing in the folder. This is the resolution which was presented on the floor by Dr. Walls. There was some discussion from many quarters as to whether or not the Councilor term might be too long, and also as to whether it was advisable to have Councilors re-elected indefinitely, if their constituency so desired. The resolution is very short.

"WHEREAS, The councilorship in the Michigan State Medical Society is now five years and continued re-election possible; and

"WHEREAS, A longer term of service may make an undue demand on members who have served their local societies long and well; therefore be it

"RESOLVED, That the By-Laws be amended so that a councilorship be of three years duration rather than five and no councilor may succeed himself but once."

That was discussed at length in the Committee, and we had the advice of members of The Council in that Committee, and both parts of this resolution did not seem advisable to the Committee—unanimously. Therefore, the Committee disapproves both of the change in duration of the term of the Councilorship, which is now five years, and also of any limitation on the number of times that a Councilor may be elected.

I move the disapproval of this resolution.

THE SPEAKER: Is that motion seconded?

F. A. WEISER, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? The motion is for the disapproval of this resolution. If there is no discussion, we will proceed to vote. All in favor say "aye"; opposed, "no." The motion is passed and the resolution is defeated.

IX—p. MOTION TO INSTRUCT THE COUNCIL TO MAP OUT TWO NEW COUNCILOR DISTRICTS

T. K. GRUBER, M.D. (Wayne): Mr. Speaker.

I move that The Council be instructed to map out the two new Councilor districts in Wayne.

W. S. REVENO, M.D. (Wayne): I second the motion.

THE SPEAKER: You have heard the motion, which has been seconded by Dr. Reveno of Wayne. Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is carried.

Dr. Spalding, is there further business from your Committee?

E. D. SPALDING, M.D. (Wayne): No, I move the report of the Committee as a whole, both as to Constitution and By-Laws and Petition and Councilors' terms be accepted.

THE SPEAKER: You have heard the motion. Is there a second?

E. D. KING, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." Motion is passed.

Thank you very much, Dr. Spalding.

XII—e. CONSULTATION OF DOCTORS OF MEDICINE WITH OSTEOPATH

The next order of business is the Report of the Reference Committee on Resolutions. Dr. Bromme.

Dr. Bromme was congratulating himself last night on being all through work.

Gentlemen, I asked for new business this morning, and no resolutions were presented. I understand there are other resolutions. However, those resolutions will have to be referred to some committee for reference, so when we are through with our morning's business, if anyone has a resolution, the floor will be open to you.

WILLIAM BROMME, M.D., (Wayne): A resolution presented by Macomb County was discussed yesterday evening, and it was suggested by the Chair that recommendations from the floor be received by this Committee, to which the resolution was referred for reconsideration.

This resolution is as follows:

"RESOLVED, That the Macomb County Medical Society desires to have clarified the status of consultation of Doctors of Medicine with Osteopaths on serious cases, and the question of Doctors of Medicine professionally visiting their patients who have been taken to an Osteopathic Hospital as an emergency case, when their condition is such that transfer to another hospital is not advisable."

The Committee thought, and still thinks, that this is not within the purview of the Committee, but acting on the insructions of the House of Delegates last evening, the Committee has the following comment to make:

"This resolution calls for the clarification of an intangible situation. This matter is covered, contrary to the statements by a member of the House yesterday evening, in the June, 1948, revision of the Code of Ethics of the American Medical Association, which was the impression of our Committee in its original report.

"The Code of Ethics states in Chapter 2, title, Duties of Physicians to Their Patients, Section 1, labeled Standards, Usefulness, Nonsectarianism:

" 'In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness to the same end he does—"

(Dr. Bromme continued reading from the Code of Ethics concluding with the phrase—

"—in the same degree in which it elevates the honor and dignity of the doctor in training and practice.' "

(The copy from which Dr. Bromme read was not included in the file of the committee.)

It was suggested from the floor yesterday evening that this was a matter to be handled at the local level. Your Reference Committee feels that if this matter could be handled at the local level this resolution would never have been presented to the House of Delegates.

The recommendation of your Reference Committee on Resolutions is that this resolution be referred to The Council of the Michigan State Medical Society, and I so move.

THE SPEAKER: You have heard the motion. The motion is that this resolution be referred to The Council of the Michigan State Medical Society. Is there a second?

L. J. BAILEY, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion on this maneuver?

H. W. WILEY, M.D. (Ingham): Mr. Speaker, it seems to me that we should ask The Council to take some action on it. I think it is time you did something about this.

THE SPEAKER: The suggestion has been made that The Council take some action. Do you care to propose any amendment to the original motion? Do you care to ask for action?

H. W. WILEY, M.D. (Ingham): I would like to amend that, that they be asked to take some action.

THE SPEAKER: The amendment has been proposed that The Council be asked to take some action. Is there support for that?

T. Y. HO, M.D. (Clinton): I second it.

THE SPEAKER: Is there any discussion on the amendment, that The Council be asked to take some action?

R. A. SPRINGER, M.D. (St. Joseph): Immediate action.

THE SPEAKER: That is a suggestion—immediate action. The Council can't meet before noon.

W. S. REVENO, M.D. (Wayne): Mr. Speaker and Members of the House: I think rather than to leave the matter as has been suggested, I would like to make even a little more specific instruction by amending the amendment, to the effect that the resolution be referred to The Council of the Society with the suggestion that they in turn refer the matter to the Committee on Ethics for adjudication or for a ruling.

THE SPEAKER: The amendment to the amendment is that the stipulation be given to The Council that after consideration the whole matter be referred to the Committee on Ethics of the Michigan State Medical Society for ruling. Is there any support to that amendment?

F. G. BUESSER, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion on the proposed amendment to the amendment?

T. K. GRUBER, M.D. (Wayne): My comment may not be exactly on the amendment to the amendment, but my comment is on the report that Dr. Bromme read.

The excerpt from the ruling of the Judicial Council of the American Medical Association is very fine verbiage. I don't believe that even the great Judicial Council of the American Medical Association could interpret it. I don't believe the American Medical Association has gone into the matter and really brought out a ruling on the subject that is worth while.

I don't want to have Dr. Bromme read it again, but I think if you would listen carefully to it, when you got through you would be right where you started. I think it is a very foolish presentation that the Judicial Council of the American Medical Association has made, and they have ducked the issue.

THE SPEAKER: Is there any further discussion on the amendment to the amendment?

C. I. OWEN, M.D. (Wayne): This is just a short discussion on the subject. We are in Delegates' Session. The Council acts in our absence. It is much less representative of the profession than this group. I don't believe we ought to pass the buck to The Council.

THE SPEAKER: Is there any further discussion on the amendment to the amendment?

If not, we will proceed to vote on the amendment to the amendment, which is to the effect that The Council be instructed to refer this to the Ethics Committee. If you vote "yes" you will vote for The Council to refer it to the Ethics Committee.

PRESIDENT LEDWIDGE: May I speak on that?

THE SPEAKER: Yes, Dr. Ledwidge.

PRESIDENT LEDWIDGE: I take it you mean the Ethics Committee of the State Society. What have they to do with it? Are they to have full authority to decide it? After all, they are a committee of The Society. Are they to be given full authority? Otherwise they will refer it back to The Council for further discussion.

THE SPEAKER: Is there any further discussion?

S. L. LOUPEE, M.D. (Cass): We are told that The Council is the executive body of this organization, and so it is. As such, it is its policy to execute the orders given by the House of Delegates. The House of Delegates at this very moment seems not to have the determination to make a decision which is in our lap. I think the decision should come from us, and leave the execution of it in the hands of The Council.

THE SPEAKER: If you are in favor of referring this to The Council to be referred to the Ethics Committee, vote "yes." If you are opposed to that particular vote, vote "no." Any further discussion?

L. C. HARVIE, M.D. (Saginaw): The Ethics Committee can make no decision. It is only a fact-finding committee and must refer its findings back to The Council, so I see no purpose in referring it to the Ethics Committee.

D. C. BLOEMENDAAL, M.D. (Ottawa): The thing we are discussing happens every day. A patient goes to a Doctor of Medicine and then goes to an Osteopath. I don't think we have to get so stewed up about it. It happened not long ago in our county. A man refused to go out or couldn't go out, and the patient went to an osteopath and got along all right, and nothing more was said about it. So I don't know whether we know all the facts about this local problem. I don't know whether the House of Delegates should act on this or not. I feel that it is more or less a personal problem and if the Osteopaths are that much better than the regular physician, let the patient go to the Osteopath. That is the way I look at it.

THE SPEAKER: Is there any further discussion?

Gentlemen, I will ask you to limit your discussion to the amendment to the amendment. That is all we are discussing now—whether this should be referred to the Ethics Committee or not. Of course, if you pass the amendment to the amendment it will carry the amendment and the motion. In other words, the entire resolution will be referred with instructions.

D. B. WILEY, M.D. (Macomb): I happen to be the one who presented this resolution on behalf of Macomb County. Possibly my

remarks are not entirely on the amendment to the amendment. If I am in error, I expect the Speaker to correct me.

THE SPEAKER: That is all right. Go ahead.

D. B. WILEY, M.D. (Macomb): However, probably there are some further explanations that are due the House. They have been given to the Committee on Resolutions, and notwithstanding the remark of the Chairman, that this was a local problem, we do not feel that this is a local problem, in Macomb County.

Macomb County has approximately fifty-six Doctors of Medicine and thirty-three Doctors of Osteopathy. Let's refer to them as osteopaths. In that proportion, the percentage of Wayne County would be well over 1200, and the number in the State of Michigan would be approximately 3000.

There is no question but that all of our every-day practice is tied up with ethics. However, this probably should be considered as a matter of policy also.

If it is in the power of the House of Delegates to determine what should be done with such a problem, if it is their desire, they may pass this on to The Council, which is the executive body of the House of Delegates, to consider these matters between the annual sessions of the House of Delegates, but as far as Macomb County is concerned, we have no particular trouble with our own members but we do not have any jurisdiction over members of the other county societies, who may come into Macomb County and act in the osteopathic hospitals.

Probably there are similar circumstances throughout the state, perhaps not to the same extent that there is in Macomb County. Let's hope that there is not and will not be any such influx throughout the state as there has been in our own particular county. Thank you.

THE SPEAKER: Thank you, Dr. Wiley.

Before we proceed to a vote or further discussion, I am going to ask Dr. Bromme to read the resolution again, in order that you may be sure what you are voting on.

WILLIAM BROMME, M.D. (Wayne): You must realize that the Committee also attempted to obtain clarification of the resolution so there could be a cut and dried question presented to the House instead of a request for clarification.

The resolution is as follows:

"RESOLVED, That the Macomb County Medical Society desires to have clarified the status of consultation of Doctors of Medicine with Osteopaths on serious cases, and the question of Doctors of Medicine professionally visiting their patients who have been taken to an Osteopathic Hospital as an emergency case, when their condition is such that transfer to another hospital is not advisable."

That is the resolution presented to your Committee.

THE SPEAKER: Is there any further discussion on the amendment to the amendment which is what we are discussing now?

PRESIDENT LEDWIDGE: Mr. Speaker, may I ask one point for clarification?

THE SPEAKER: Dr. Ledwidge of Wayne.

PRESIDENT LEDWIDGE: I am not quite clear on all the amendments. Will you read the motion, the first amendment and the amendment to the amendment?

THE SPEAKER: The motion as presented by Dr. Bromme—I will ask him to read the motion.

WILLIAM BROMME, M.D. (Wayne): The motion was that this resolution be referred to The Council of the Michigan State Medical Society.

THE SPEAKER: Thank you. The amendment to the motion was that it be referred to The Council with instructions to act, and the amendment to the amendment was that The Council be instructed to refer the matter to the Ethics Committee. We are now voting on the amendment to the amendment, which would carry the amendment and the motion. In other words, if the House of Delegates does not care to decide this matter, it will be referred to The Council with instructions to refer it to the Ethics Committee.

PRESIDENT LEDWIDGE: Mr. Speaker, I still feel that doesn't take care of the matter, because after this has been referred to the Ethics Committee, what from there on? Are they to be voted authority to decide it? Are they to refer it back to The Council? What is going to be done with it?

THE SPEAKER: Is there any further discussion on this matter?

W. S. REVENO, M.D. (Wayne): When I offered the amendment to the amendment, I specified that The Council refer this matter to the Ethics Committee of the State Society for an opinion. That opinion is to come back to The Council of the State Society, and The Council then transmits that opinion to the group inquiring or introducing this resolution.

THE SPEAKER: In other words, gentlemen, if you pass this amendment to the amendment, this will be referred to the Ethics Committee for an opinion. That opinion will be transmitted back to The Council, and The Council will transmit the opinion back to the county medical society in Macomb.

Is there further discussion? If you pass this motion that will be done.

PRESIDENT LEDWIDGE: I still object to it. It is contrary to everything in the working of The Council and the Committee.

THE SPEAKER: You object to what?

PRESIDENT LEDWIDGE: That procedure. I think that should be referred to The Council to use their judgment, with the instructions they have, if you wish, but it certainly should not be referred through The Council to the Ethics Committee and back to the parent body, who has to approve the opinion of the Ethics Committee rather than give it to the Ethics Committee and let them approve it.

THE SPEAKER: If you agree with Dr. Ledwidge, you will defeat the amendment to the amendment. If you do not agree with Dr. Ledwidge and want it referred indirectly to the Ethics Committee, you will vote "yes." If you vote "yes" before The Council, it goes to the Ethics Committee. If you vote "no" we will consider the amendment and the original motion.

All in favor of the amendment to the amendment say "aye"; opposed, "no." The amendment to the amendment is defeated. The question before the House now is the amendment, that the resolution be referred to The Council with instructions to act. Is there any discussion on this amendment?

If not, all in favor say "aye"; opposed, "no." The Chair will ask for a raising of the hands. All in favor of this amendment will please raise their right hands. If you vote "yes" it is to be referred to The Council with instructions to act. All opposed to this motion will raise their right hands.

This motion on the amendment has carried 53 to 37. It is not necessary to vote on the motion because the amendment carries the motion, and the resolution will be referred to The Council with instructions to act.

Dr. Bromme, do you have any further business?

WILLIAM BROMME, M.D. (Wayne): We have one resolution, sir. That is the resolution presented yesterday evening by Dr. Barone—

XII—e. TO INCREASE NUMBER OF MEDICAL GRADUATES

"RESOLVED, That the Michigan State Medical Society, through its Officers, initiate a movement to increase the number of students graduated from the medical schools in this State and that the Delegates to the AMA initiate a similar movement on a national basis, to increase the number of physicians graduated and that the Delegates to the American Medical Association initiate a movement to establish new medical schools in those states where none now exist."

The Reference Committee went over the preamble to this resolution with considerable care, because there were a number of loose statements in it which are not supported by facts, and the preamble to a resolution must contain facts on which the conclusion can be based.

One statement is to the effect that the Ewing Report states that there is a 20 per cent shortage of physicians. There is no copy of the Ewing Report available. That is a report culled from a newspaper, from a report submitted by Mr. Ewing, the Federal Security Administrator. We think that is a very sketchy basis on which to formulate a decision of this body.

There is another statement—

"WHEREAS, The present curbing of graduates and/or admission is due to postwar regulations and controls of the American Medical Association."

That is information which is not subject to proof or disproof by the Committee, so the Committee rewrote the preamble and the resolution and submits it as an alternate resolution.

"WHEREAS, There is general agreement as to the need for a larger number of physicians and

"WHEREAS, The facilities for teaching are not sufficiently increased to provide hope in the near future of answering the need for a larger number of physicians, and

"WHEREAS, The number of individuals other than Doctors of Medicine licensed to practice the healing art in the State of Michigan has increased materially, therefore, be it

"RESOLVED, That the Michigan State Medical Society, through its officers, support any reasonable means to increase the number of students graduated from medical schools in this State, and that the Delegates to the American Medical Association take similar action at the next meeting of the American Medical Association House of Delegates."

Mr. Speaker, the Reference Committee on Resolutions proposes that this alternate version of the resolution be considered by the House, and I move its adoption.

THE SPEAKER: You have heard the motion. Is it supported?

O. K. ENGELKE, M.D. (Washtenaw): I second the motion.

THE SPEAKER: Is there any discussion on this motion to approve the resolution as amended by the Committee?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

Do you have any further business Dr. Bromme?

WILLIAM BROMME, M.D. (Wayne): Mr. Chairman, this completes the resolutions as presented to the Resolutions Committee. I move the acceptance of the report of the Resolutions Committee as a whole.

THE SPEAKER: Is that motion supported?

E. D. KING, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." Motion is passed.

WILLIAM BROMME, M.D. (Wayne): Mr. Speaker, may I take this moment to thank very much the personnel of the Resolutions Committee. None of us had worked together as a Reference Committee before. Some of us are neophytes to the problems of Reference Committee work, and certainly I am very happy to have had Dr. Carpenter, Dr. Fenton, Dr. Harris, Dr. Holtom, Dr. Kullman and Dr. McKean on this Reference Committee.

THE SPEAKER: Thank you, Dr. Bromme.

I should also like to assure Dr. Bromme that I don't believe he is through work.

With the permission of the House, the Chair would like to refer back to New Business and ask if there are any other resolutions that any delegate cares to present this morning.

IX—q. HOUSE OF DELEGATES RESOLUTIONS TO BE PRESENTED 30 DAYS PRIOR TO SESSION

H. H. RIECKER, M.D. (Washtenaw): May I apologize for offering a resolution at this late time. This resolution concerns resolutions.

"WHEREAS, Many resolutions presented to the House of Delegates at its Annual Session should receive more adequate consideration than time permits under the present procedure, and many implications arising in association with these resolutions require consultation with officers and members of the county societies before a truly representative opinion can be formulated, therefore, be it

"RESOLVED, That all resolutions to be presented to the House of Delegates in Annual Session be delivered to the Secretary of the Michigan State Medical Society not later than thirty days prior to the date of the meeting. Further, that copies of all such resolutions be forwarded by the Secretary to the secretaries of component units of the Society as well as the officers and appropriate committees for their consideration prior to convocation of the House of Delegates.

"The action proposed in this resolution is to be considered as a ruling of procedure and not an amendment to the By-Laws."

The latter is put in there so if the House accepts this and desires to change it later, that can be done.

THE SPEAKER: You have heard the resolution. The Chair will refer this to the Reference Committee on Resolutions.

Dr. Bromme wishes the floor.

WILLIAM BROMME, M.D. (Wayne): The only reason the Chairman of the Committee on Resolutions stuck out his neck and let Dr. DeTar open the gate for this was because we knew this resolution was on the way. The Committee saw it last night and discussed it, and has an action to present, if you will accept the supplemental report of the Reference Committee on Resolutions at this time.

THE SPEAKER: This is probably the first time on record that a Reference Committee has ever considered a resolution before it was thought up.

If there is no objection on the part of the delegates, we will consider the report of the Reference Committee at this time.

WILLIAM BROMME, M.D. (Wayne): As a matter of fact, we saw this in time. The only formality was that it had not been presented to the House of Delegates, so the Committee did not feel that it was jumping the gun in seeing something which was already in published form.

The resolution is proposed by Dr. Riecker—

"RESOLVED, That all resolutions to be presented to the House of Delegates in Annual Session be delivered to the Secretary of the Michigan State Medical Society not later than 30 days prior to the date of the meeting. Further, that copies of all such resolutions be forwarded by the Secretary to the secretaries of component units of the Society as well as the officers and appropriate committees for their consideration prior to convocation of the House of Delegates.

"The action proposed in this resolution is to be considered as a ruling of procedure and not an amendment to the By-laws."

This resolution bears the approval of your Resolutions Committee, and I move its adoption.

THE SPEAKER: Is that motion supported?

R. L. WADE, M.D. (Branch): I second it.

THE SPEAKER: Is there any discussion on the motion to adopt the resolution?

L. W. GERSTNER, M.D. (Kalamazoo): That eliminates one-twelfth of the year in the deliberations of any one county society. I can conceive that the problem of a resolution is going to arise during the year. It may arise the first month, the second month, or the third month. This is a new one. I hadn't thought it over. I can conceive its arising in the last month and depriving that component society of presenting that resolution which arose in the month preceding this Annual Meeting, were it to be made a rule.

H. H. RIECKER, M.D. (Washtenaw): Will you read the last paragraph of the resolution?

WILLIAM BROMME, M.D. (Wayne): You omitted the last paragraph, so I did, too.

H. H. RIECKER, M.D. (Washtenaw): I didn't know the question would come up. So maybe we had better go ahead.

THE SPEAKER: The question arises whether the resolution is as printed or as given verbally. Dr. Riecker has asked that the last part be read. We are not voting on the last paragraph at present, because the motion has been made that the resolution be adopted as read.

With the permission of the House, I will ask Dr. Bromme to read the last paragraph for consideration.

WILLIAM BROMME, M.D. (Wayne): "This ruling does not preclude the presentation of a resolution during a session of the House of Delegates if its urgency is agreed upon by the President of the Michigan State Medical Society, the Secretary, and the Speaker of the House, acting as a committee."

That also was agreeable to the Resolutions Committee.

THE SPEAKER: Before we go ahead with any additional discussion—and this is simply considered as a suggestion which could be made as an amendment if anyone cares to propose it, I would like to ask the Secretary of the Society to tell us his opinion on this, because he has been wrestling with this problem for years.

Dr. Foster!

SECRETARY FOSTER: I, too, saw this resolution last night and was surprised when the last paragraph was not read, because it is perfectly obvious that there are emergency situations, that could arise in the last month, and that the provision would have to be made whereby somebody could give the opinion that they were emergencies and have them presented.

As a matter of fact, this same procedure, to a certain extent, is followed in the American Medical Association. It was felt here, in the original draft of this as presented, when it was first shown to me, it was said that the Secretary of the State Society should get these resolutions thirty days prior to this meeting and that he should then transmit them to the delegations and the Chairmen thereof.

I can assure you, gentlemen, that in the last thirty days prior to this meeting it would be quite impossible for the Secretary of the State Medical Society to know who the chairmen of the delegations of fifty county societies would be, and it was my suggestion, if it was a question of information to be gotten to the various groups, it would be much more practical to have the resolutions presented thirty days in advance, have them mimeographed in the executive office and transmitted to the fifty-five county secretaries, who in turn were in close touch with their delegations and their societies, and they could much better and much more practically transmit the resolutions to those people who were interested in studying the provisions thereof.

THE SPEAKER: Is there any further discussion?

Dr. Gruber, I am sorry. Dr. Babcock of Wayne asked for the floor. However, if you take the floor now, he can be coming to the platform.

T. K. GRUBER, M.D. (Wayne): I am convinced that this is a very impractical suggestion. The Wayne Delegates are elected at the last meeting in May, and from then on until fall they are away on their vacations and various things, and there are no meetings held during the summer.

About a month ago we convened the delegates to see what ideas they had. We appointed committees to sort them out. We had three meetings. The last was Friday last, at which the resolutions to be presented by the Wayne Delegation were formulated and agreed on by the Wayne Delegation.

If we have to get those resolutions in thirty days ahead of time, it is going to be a hardship, and I think you will find that each county society is in about the same shape. We are all procrastinators. After all, the problem comes down finally to the place that you get your ideas on paper.

At the American Medical Association, they don't bring them in. They present them on the floor of the House.

There are many controversial subjects that the county societies have. They don't want the discussion beforehand. They want to bring it down and spring it as a surprise. That is one of the things that the human race likes to do.

I certainly hope we will not pass this resolution.

W. W. BABCOCK, M.D. (Wayne): Dr. Gruber has brought out many of the points that I wanted to bring out. I merely wish to implement those. I feel that passing this resolution would definitely take away the prerogatives of the delegation and would weaken the voting power of this democratic assembly.

THE SPEAKER: Is there any further discussion on the motion?

H. H. RIECKER, M.D. (Washtenaw): I have been a delegate here for about five years, and during that time, every year there have been certain questions brought up in resolutions which I would like to talk over with someone in my own county, and all the other delegates in my county—there are only five of us—have that same opinion. We would like to have a little more time in which to consider some of these things, which in certain cases affect our county vitally. There are one or two in this meeting which do.

It is to my mind more democratic to give us a chance to get the opinion of the leaders in our county societies, the men concerned in certain problems. When they are brought on the floor of the House so suddenly, we have no time to telephone to Ann Arbor or Ypsilanti or Milan, or wherever it is, to find out the opinions of the men and to get their advice that we need so badly before we vote on the resolution.

The whole point is, to my mind, to make the thing more democratic, to give a broader base upon which to make it, to decide how this resolution is going to affect our community and our state.

Thank you.

THE SPEAKER: Dr. Riecker, do you care to propose any amendment to make this a little more elastic, so business can be brought up in thirty days? Your last paragraph was not included in the resolution.

H. H. RIECKER, M.D. (Washtenaw): In formulating this there was a great deal of discussion about the time, thirty days or two weeks. I thought two weeks was enough to have, for the resolutions to be brought to the attention of the local delegations.

I propose an amendment of the last paragraph, Mr. Speaker.

THE SPEAKER: Dr. Riecker moves the adoption of an amendment, consisting of the last paragraph which was not read. I will ask Dr. Bromme to read the last paragraph.

WILLIAM BROMME, M.D. (Wayne): "This ruling does not preclude the presentation of a resolution during the session of the House of Delegates if its urgency is agreed upon by the President of the Michigan State Medical Society, the Secretary, and the Speaker of the House, acting as a committee."

THE SPEAKER: Does anyone support this proposed amendment?

R. W. TEED, M.D. (Washtenaw): I support it.

THE SPEAKER: Is there any discussion on the amendment?

R. J. ARMSTRONG, M.D. (Kalamazoo): Mr. Speaker, having had the courage to get this far in the front, I am disgusted with this House of Delegates in this Session. I haven't heard half a dozen voices come out and talk. I think you are giving away your prerogatives. If you are going to give this last one away, I think you might as well stay home.

THE SPEAKER: Is there any further discussion on the amendment?

L. C. HARVIE, M.D. (Saginaw): Why should any resolution have a board of censors before it is presented before this organization?

THE SPEAKER: Is there any further discussion?

If not, all in favor of the amendment—I think you remember the amendment and I don't need to repeat it—will say "aye"; opposed, "no." The amendment is defeated.

Is there any further discussion on the motion to adopt the resolution? If there is no further discussion on the motion, those in favor of adopting the resolution say "aye;" opposed, "no." The motion is undoubtedly defeated.

Is there any further business, Dr. Bromme?

WILLIAM BROMME, M.D. (Wayne): The Reference Committee on Resolutions has presented its full report and requests that its report be accepted as a whole and that the Committee be discharged.

THE SPEAKER: Is there a second?

E. G. KRIEG, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye;" opposed, "no." The motion is passed.

There is one more Reference Committee I would like to ask for right now, and that is, I would like to know if there is a supplemental report from the Reference Committee on Special Memberships.

J. J. LIGHTBODY, M.D. (Wayne): There is. We will take just a moment.

THE SPEAKER: You may be thinking about this while he is coming up. I am going to ask you whether you would like to recess this session after this report, or whether you would like to get into the Report of the Reference Committee on Ethics.

J. J. LIGHTBODY, M.D. (Wayne): Mr. Speaker and Delegates: There is very little of a controversial nature that our Committee has had anything to do with. Most of our difficulty has been in finding out whether a man is seventy years of age or sixty-nine, or whether his dues have been paid up. I don't think it will take more than a moment here for me to give you the Committee's report.

XII—f. ON SPECIAL MEMBERSHIPS

We have had a few more resolutions for special memberships.

Name	*County*	*Type of Membership*
Lewis Bracey, M.D.	Ionia Montcalm	Life
W. E. Jewett, M.D.	Lenawee	Life
R. W. McLain, M.D.	Jackson	Life
Henry Herzer, M.D.	Calhoun	Life
Charles Heald, M.D.	Calhoun	Life
W. O. Upson, M.D.	Calhoun	Life
Benjamin Franklin, M.D.	Mecosta	Life
C. E. Long, M.D.	Ottawa	Life
George L. Bond, M.D.	Kent	Life
Simeon LeRoy, M.D.	Kent	Life
Burton Corbus, M.D.	Kent	Life
J. R. W. Kirton, M.D.	Houghton	Emeritus
H. Landon, M.D.	Monroe	Emeritus
Joseph Whinery, M.D.	Kent	Emeritus
Frederick Baker, M.D.	Oakland	Retired

Mr. Chairman, I move the adoption of these resolutions for special memberships.

THE SPEAKER: Is that motion supported?

B. G. HOLTOM, M.D. (Calhoun): I second it.

THE SPEAKER: Is there any further discussion on the motion to grant these special memberships by the adoption of this motion? If there is no discussion, all in favor say "aye"; opposed, "no." The motion is passed.

Dr. Lightbody.

J. J. LIGHTBODY, M.D. (Wayne): There have been a few applications for special memberships which the Committee had to consider, and because of incomplete qualifications and specifications for these memberships, they had to be turned down. I know that some of the resolutions have asked for certain members to have certain types of special memberships.

In case there have been men whose names have been presented to the Committee for special memberships and they have not been brought before the House up to this time, if the delegates will consult me after this meeting I will discuss with them why those men have not been considered for the special memberships, or at least the reasons why they were not approved for special memberships.

Mr. Chairman, I move the adoption of this Committee's report as a whole.

THE SPEAKER: Is that motion supported?

F. G. BUESSER, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed. Thank you very much, Dr. Lightbody, for your splendid work.

Is there any other business to come before the House?

Gentlemen, the next order of business is the report of the Reference Committee on Ethics. Now I should like to ask the pleasure of the House in this regard. Would you rather have the report of this Reference Committee now? Would you rather meet in an hour and have it, or would you rather consider it in the regular session, which is the meeting convening at eight o'clock tonight?

Will all those who wish to put over the rest of the business of the House until the next meeting at eight o'clock tonight, please raise your hands?

Thank you. That is the majority, and in a moment we will recess. However, I should like to ask if any of the Reference Committee chairmen care to have meetings of the Reference Committees this afternoon. If so, please get a message to me at once.

(Announcements.)

Is there any further business to come before the House?

If not, I hope you all will enjoy the ball game, and I will see you at eight o'clock.

(The meeting recessed at one o'clock to reconvene at eight o'clock the same day.)

Fourth Meeting

Tuesday Evening, September 21, 1948

The meeting convened at eighty-thirty o'clock, J. S. DeTar, M.D., the Speaker, presiding.

THE SPEAKER: The House will come to order.

Dr. O'Meara, are you ready to report?

J. J. O'MEARA, M.D. (Jackson):

I have the names of 94 members whose credentials have been signed by the proper officials of the different county medical societies. This, of course, is more than 40 per cent of the accredited delegates, and 50 per cent of which is not from any one individual county.

THE SPEAKER: Thank you, Dr. O'Meara, for your final report. Congratulations for handling it so beautifully.

I am sorry to have to give you this announcement that our Public Relations Counsel, Hugh Brenneman, who became ill last Friday, became much worse today and was taken to Harper Hospital under Dr. Reveno. He is now receiving intravenous treatment and penicillin and he is quite ill. It seems to me that, since Hugh Brenneman rendered great service to us and is a very valuable man, that it would be very appropriate if we would send him some sort of token.

IX—r. MOTION TO SEND BEST WISHES TO PUBLIC RELATIONS COUNSEL—HUGH W. BRENNEMAN, ILL

C. L. WESTON, M.D. (Shiawassee): I move that the House of Delegates send a message of regret to Hugh W. Brenneman, accompanied by a huge bouquet of flowers.

THE SPEAKER: Is that seconded?

R. W. TEED, M.D. (Washtenaw): I second it.

THE SPEAKER: All in favor of the motion say "aye"; those opposed, "no." It is carried.

Gentlemen, there was one very short speech made this afternoon that caused me some concern. That was the speech by Dr. Armstrong of Kalamazoo. He came to the rostrum and said he was definitely disappointed in this House of Delegates. He made the suggestion that perhaps the decisions of this House were determined to some extent by the minority of the membership of this House.

As Speaker of the House, gentlemen, I urge the utmost freedom of discussion. Now if the Chair has not provided that freedom of discussion, then my apologies to the House. I hope that every delegate will do his utmost to represent his constituents, not only in the voting but also verbally. I think that is only our duty to the men we represent.

Will the Vice Speaker take the chair and carry on with the agenda?

(R. H. Baker, M.D., Vice Speaker, took the chair.)

THE VICE SPEAKER: The next order of business is Unfinished Business. Is there any other unfinished business to come before this meeting?

DOUGLAS DONALD, M.D. (Wayne): Mr. Speaker, does my report come under Unfinished Business—the Report of the Reference Committee on Ethics?

THE VICE SPEAKER: We will get you on the Reference Committees.

Is Dr. Beck here?

Are there any supplemental reports from The Council or from any standing committees?

Is there a report on the Reference Committee for standing Committees?

E. G. KRIEG, M.D. (Wayne): None.

THE VICE SPEAKER: Is there any report for the Reference Committee on Special Committees?

G. C. STUCKY, M.D. (Eaton): No.

THE VICE SPEAKER: I think the Constitution was closed.

Is there any other report from the Committee on Resolutions?

WILLIAM BROMME, M.D. M.D. (Wayne): No.

THE VICE SPEAKER: I guess then we are ready for the Report of the Reference Committee on Ethics. There is still some unfinished business left over from this morning.

Dr. Donald.

XII—h. ON ETHICS

DOUGLAS DONALD, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: This Committee on Ethics has received two resolutions. The Speaker promised us there was to be only one, but he did not keep his word.

XII—h. RESOLUTION OF SECTION ON OPHTHALMOLOGY

The first resolution was presented by the Special Committee of the Section on Ophthalmology of the Michigan State Medical Society. This resolution started with a long preamble, followed by the resolution.

Your Committee has surveyed the preamble and has gone on to the resolution, and our report will be upon the resolution.

A great deal of thought was given to this. A long time was given to hearing from the Michigan Ophthalmology Society. Their problems were discussed.

After discussion, your Committee is proposing a revised resolution, which I shall read. This is the resolution as revised by your Reference Committee on Ethics:

"WHEREAS, We propose to continue to conduct the practice of medicine according to the experience and judgment of a responsible medical profession, working from the scientific, sociological, and economic angles according to plans based on experience to increase the distribution of good care,

"WHEREAS, The Michigan State Medical Society is in the habit of looking at its problems squarely, fearlessly, honestly, and by analysis, and

"WHEREAS, After analysis to approach new methods as scientific men should, by planning and experimentation, knowing that the complicated subject of economics in any segment of medicine cannot suddenly be changed by any single formula or law,

"WHEREAS, According to the principles of medical ethics it is unprofessional to accept rebates on prescriptions, appliances or perquisites from attendants who aid in the care of patients, we believe it will be the consensus of the House of Delegates that the membership of the Michigan State Medical Society and of the medical profession in general is as honest and as much to be trusted in all of its responsibilities as any other group of citizens, be it therefore

"RESOLVED, That it is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"That We urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

Mr. Speaker, I move the adoption of this revised resolution from the Ophthalmological Section.

THE VICE SPEAKER: You have heard the motion as revised. Is there a second?

E. D. SPALDING, M.D. (Wayne): I second it.

THE VICE SPEAKER: Is there any discussion?

R. H. PINO, M.D. (Wayne): Mr. Speaker, I think this resolution, as it has been revised by the Committee, covers the subject very well. I think a point has been left out that we had in there, covering any therapeutic agent, that the Doctor of Medicine should be responsible to the patient and be in position to handle that therapeutic agent as he feels best, even if he has to buy, let us say, drugs at wholesale and sell them to the patient for nothing or for a price consistent with the doctor's charges, which we all know are from anything or nothing up to reasonable charges.

I hope that you have read the resolution and the preamble as it was handed out to you. I am discussing this now. I will vote for that resolution as it is suggested.

I think, however, that there is so much misunderstanding that there comes a time when the delegates of the Michigan State Medical Society should have a subject of this type reviewed before them, in order that they may be able to answer some of the problems that arise, for we are dealing here with a subject that has shaken the foundations of medicine in America.

I would not spend time on this if it were a personal matter. It has been nearly ten years since the subject of rebates has affected my practice. I have handled it in another way, from dispensing in the interests of my patients from my office, and that is the way it should be done under the circumstance of all that is included in this great subject. In other words, through the use of medical associates, as one method, we will come to know that if we are going to protect the patient's interest from the standpoint of his glasses, we have to be in position to control that, and I think the resolution calls for it all right.

Let's remember just a few of these things. We are dealing here with statutory law, and we are dealing with ethical law. We are dealing with the distribution of medical care, and we are dealing with the science of medical care.

We have been brought straight up against certain laws, considering this from the standpoint of statutory law, namely the Sherman Act, which was passed around the turn of the century, when Theodore Roosevelt was wielding the big stick, and gradually the Government has been trying to use this. Now, as pointed out in the preamble to the resolution, 65 per cent of the prescribing of glasses is done by the optometrist, in all kinds of places. I do not need to name them, nor to discuss the blinking eyes in the window and things of that type that attract the patients. I hope you will make note of that there.

But what happens? In 1940 the Federal Government lost its suit against the large optical companies. It loses its suits to a very great extent when brought against companies that are sufficiently large; I might say General Motors. I am not sure that any suit has been brought against General Motors for obstructing the distribution of automobiles, but that is a little bit too big to handle.

Now they lost this suit. Let me make this statement. I am absolutely for the Federal Government in this case, and so are all of the other ophthalmologists who know about it. I am for them from the standpoint of rebates, for rebates have come to be considered an accessory to collusion in monopoly. Let me say this, that by consent decree rebates will be out in the United States shortly.

Having lost their case, this is what happened. They said, "Well, what accessory to this can we find?" And so it turned out that they could pick out about fifteen per cent of those who prescribe glasses and attach them to the suit, which they have done, wherever they could get that.

I said a few minutes ago that not since 1940 have I dealt in this from the rebate standpoint, which I uphold, or have up to such time as different arrangements can be made for a reason which I can tell you. But I bring this to you as what will be the case in event medicine is taken over by the Federal Government. You will be subservient to a police type of thing that you are not in the habit of having, and I want to give one illustration.

The Government went into the records of the optical company, that is concerned in the current suits, and there they found that two patients of mine in the time covered by these suits had taken their prescriptions. I am not certain just where they were, but I understand that one was in the State of Nevada and another I think in Nebraska. At any rate, I have the letter that I could read to you, but I will not take the time. One of these was for five dollars and something and another was for another amount. The sum total was $10.50.

To show you what public opinion can do, one morning I woke up and went down to breakfast, and here was the paper with my name spread across it, and I went down to the hospital and turned on the radio and again listened—I was one of seven men in the State of Michigan who had cost the people millions of dollars.

That is all right. I can stand that. I can get along without anything that has to do with glasses. I have gotten that far, and I think after another ten years I will have enough so that maybe I will have $300 a month for the rest of my life, but I am concerned about some of the young men who will not have to have rebates but who need some consideration in this from this House of Delegates, and I mean some sympathetic concern.

What happened? At the time that I went with Dr. Robb in 1918, we charged $3 for an eye examination. He had been with Dr. Donald Campbell, who charged $3, except for someone who maybe belonged to the D.A.C. or lived in Grosse Pointe, and maybe they charged $5 then.

How could they do it? They could do it because they made something on this commodity, 85 per cent of which was being handled by the optometrist, and on which they were making money and holding up the price.

One day I said to Dr. Campbell, "Dr. Campbell, I have just come from a meeting where they said it is wholly unethical to do that."

"Yes," he said, "young man, I know, but if you want to start in practice in Detroit, and if you want to fix it so that the people can't afford to come to you, as it is in New York where they charge at this time $10 to $25"—and now they charge from $25 to $50—"for an eye examination and most of your patients go to the free clinics, if you want to do that, then don't have anything to do with glasses at all, and let your patients go to the basement of Crowley & Milner and to Square Deal Miller"—and now as it is to Frank & Seder. Frank & Seder, in the drygoods business, are putting out advertising now. They want these prescriptions.

If you read more in that preamble, you will notice this, that glasses in quality range anywhere from the best, made by the highest, well-paid workmen, to those you can buy in the dollar store, and when you think of this thing, if you will notice, those of you who wear glasses, there are many times you get glasses you can't wear at all, and then there are some you can wear. Eighty-five per cent of this business is done by the optometrists.

According to some of the recent rulings—I will say rulings by public opinion—the public has been told that we should write the prescription and give that to the patient and let him go where he will. Why? In order that there might be a distribution of the business and in order that competition may bring the cost down. So we have.

Frank & Seder—I have nothing against Frank & Seder. These companies are all out after business. The Better Business Bureau comes in for its name and to make something for itself, particularly for those who run it, and so in two states the Better Business Bureau has come in and has said—they have repeated what the AMA has said—you can't blame them any—that we are parasites. Here it is in the JOURNAL, put out so that all who will may read it. Gentlemen, you can't blame the newspapers. You can't blame the *Readers' Digest*. You can't even blame the Better Business Bureaus,

although the majority (all but two states) have said, "Well, if it is this important we will leave it to the Federal Government to settle."

We said it was a problem of ethics as far as the AMA was concerned. Without their ever having gone into the facts, they have come out and said, "Yes, it is against our ethics for one to receive rebates." But is there not something else to this?

The American Medical Association waits for the Michigan State Medical Society and other societies to give the leadership, but they turn us over to the newspapers and to the Better Business Bureaus. Though the American Optical Company is dealing with 85 per cent for whom they care, they do not care about us at all. If you do have the exhibits that are referred to in that preamble there, you would know.

I have it right here, and this is in our better magazines. They go on to say: "Professional and technical services such as those illustrated are essential aids to seeing ability." Then note: "Will glasses only improve your sight?" Now they are discussing here the subject. They are taking a group of stenographers this time. "You, too, like the stenographer, should have seeing ability to meet your visual requirements. As in the case of some other stenographers, you may not be able to achieve this unaided. The only way for anyone to make sure is to seek professional guidance. Important as glasses are, their aid to your visual comfort and efficiency depends upon the professional and practical service of—" Who first? The optometrists, with whom they do 85 per cent of their business, and the Federal Government should get after them, and it is doing it, because the vast majority of the people, 85 per cent, go first to Crowley & Milner's basement, to Frank & Seder, to Square Deal Miller, and to these various places.

If they are beginning to have some difficulty with the eye, we find that they take care of glaucoma until it is too late, and today out of 250,000 totally blind in the United States, 30,000 are blind from glaucoma, and 150,000 that we know of, because we have track of them, are being treated in clinics, that are totally blind in one eye and growing blind in the other if it can't be saved. Why? Because of the great economic pressure and advertising in the medical profession.

With myself as an example, I have been brought in for $10.50.

We know what we have heard in this House of Delegates about someone who charged $7.50, as an example, for a box of ointment, was it? We know there are those cases. There are individuals everywhere, in every profession, who will take advantage of the great traditions of their profession. To license a man to practice in medicine is to license a rogue, if the man is a rogue.

Gentlemen, when public pressure comes this way, because the American Medical Association comes out and calls us parasites, and then it is picked up along the line, the pressure becomes tremendous and we fall before the avalanche of that public pressure, to the point that the Wayne County Medical Society did just lately. I want to tell you that those men there feel they are doing the right thing. I know that. But the pressure has been such, going back to this, and going back to the magazines, that even the President of the Society was brought back from his vacation in order that they might pass a resolution saying, sir, that if you prescribe anything from your office —if I am mistaken about it, doctor, you tell me—if you prescribe anything at a profit—that is, if you buy 1,000 of something or other wherever you live in Detroit and give the patient 50 of them—maybe you are not charging anything for that but you know he can't afford to go out and get it in the drug store—that is wrong as against the ethics, and so we have been blown down.

I remember some years ago when Dr. O'Meara used to lead us in some spirited singing around the piano after a meeting of the delegates, and if we were to do that now we should have as our theme song again, "Blow the Man Down." How we have been blown down!

Oh, gentlemen, this does not concern me. It would if we had to go by the Wayne County Medical Society ruling, and I shall abide by the Wayne County Medical Society ruling and I shall help the younger men to get into this in a way that it can be done.

Twenty-seven hundred years before Christ there was an ethical ruling, which became a legal ruling from the standpoint of the state in the Roman Empire, and it said that any man who opens an abscess of the eye with a bronze lens and causes the patient to lose his vision, that man shall have both hands cut off.

Ethics change. Ethics should change, but a short time ago it was unethical for a man to take a salary, let us say, from an industrial concern, and industry needed doctors, but it was unethical.

There is an evolution to law, and there is an evolution to ethics, and when the American Medical Association does not help the Doctor of Medicine in his affairs that have to do with ethics and with law and with economics, but leaves the man as it is doing, we are going to be in a mess. Because the American Medical Association did that, we were beaten carrying the case to the Supreme Court, because they are ethics.

They said that group of doctors down in Washington, or wherever it was, couldn't do that they were going to do. The men said, "Well, we are going to do what we ought to do for the people."

When I went to the American Medical Association headquarters with the outline we had for this House of Delegates, it was read to you and you spent a whole half-day on it, right from this very spot in this hotel. They said to me, "What darned nonsense! Are you a Communist?" I came back and was sustained by this House of Delegates.

I will say for the third time in this House, that when a man from the American Medical Association goes out and says there is nothing to the Sister Kenny treatment, there may be nothing to the Sister Kenny treatment, but when he hasn't sense enough to say, "We do not know as scientific men that there is anything to the Sister Kenny treatment but we will investigate and find out," when they do that, it is time that the House of Delegates of the American Medical Association, from every state, crack down on the American Medical Association and say, "Gentlemen, where is leadership?"

I am appealing to you tonight for the younger ophthalmologists of this state and for one other thing. You have led this country in things that have to do with the economics of medicine and with the science of medicine. The American Medical Association hasn't done it. It has put us in a position where there is the greatest argument from the standpoint of the government. One of the leading educators of this country said to me lately, "The greatest pressure group in the United States for socialized medicine is the American Medical Association and the mouthpiece of the American Medical Association."

Well, gentlemen, I have no fault to find with my county society or with my state society, because you are being blown down.

I see Spalding—did he go out? I saw him a few minutes ago looking at his watch, so I will quit now.

THE VICE SPEAKER: Thank you, Dr. Pino, for your very complete and comprehensive discussion of the implications in the preamble of this resolution before you. He came to a thorough defense of the ophthalmologists, one of the specialties concerned with the implications of the resolution. However, the resolution deals, because of recent publicity, with just one specialty. It would seem he has covered the field well. However, there may be other discussions.

Is there more discussion on the subject?

C. R. GATLEY, M.D. (Oakland): Could I hear the resolution again, as amended?

(Dr. Donald reread the resolution as amended.)

THE VICE SPEAKER: Does that answer your question?

F. J. KEMP, M.D. (Oakland): Yes, but I would like to make a few remarks.

I must admit that I am not the dynamic speaker that Dr. Pino is. I am very inexperienced in public speaking, but it seems to me that much of the criticism that he made was directed toward the sale of medical commodities, whether it be glasses or drugs or medicines, and that he apparently places the disposition of glasses in the same category as that of dispensing drugs or the giving of drugs to patients. I do not consider that giving any patient a few tablets or even dispensing your own medicines is a breach of medical ethics. I think that that is a part of the responsibility of any doctor who has the welfare of his patient at heart.

As a member of this delegation, I really feel humiliated to think that I should be asked to condone the unethical practice of the ophthamologist in accepting rebates from optical companies for merchandising medical commodities. This practice is, in my opinion, medical racketeering, no matter how you may choose to dress it up. If that practice is right, then, gentlemen, it is my humble opinion that it would be perfectly right for any of us to go into collusion with, we will say, ambulance drivers or with the druggists or even with the undertaker, and demand from them a cut of the financial take from any customer which the doctor may choose to send his way.

The faith in the integrity of the Doctors of Medicine, as expressed in the newspapers, magazines and by local Better Business Bureaus, has been shaken on its very foundations, as Dr. Pino has admitted, but this exposure of the Ophthalmological Society in the acceptance of rebates or dispensing medical commodities at a profit for themselves has nullified much of the progress of the Public Relations Committee with this insidious and unfavorable publicity.

I should, therefore, like to move that this original resolution, together with its dressed-up preamble, be stricken from the record in its entirety, as mute evidence that this delegation is unalterably opposed to all that it implies, and I would like, further, to move that the original resolution, as modified and deleted, will likewise be stricken from the record.

THE VICE SPEAKER: There is a motion on the floor. This motion of Dr. Kemp's is not acceptable until the vote has been taken on the motion on the floor. If that is voted down, then Dr. Kemp's motion would be acceptable.

Is there any other discussion on the motion before us?

W. B. HARM, M.D. (Wayne): Mr. Chairman, just to clarify this matter a little, I was on the Committee of Wayne County Medical Society investigating this subject. The Better Business Bureau stated that a rebate on any material used for the care of the patient for profit was unethical. Their secretary stated to me personally that while it seemed—to use the word Dr. Umphrey has applied numerous times—picayune to say that when I gave a dose of penicillin in my office to the man who needed it, I should figure it down to cents and mills, that my price should be approximately the cost of that material. They made the statement that I could charge anything I wanted for service, but in charging for that service, if the patient asked me for an itemized bill, I must itemize my service and itemize the cost of the material used and the charge should be made that way.

I make this statement just to clarify the matter, that the glasses and all other materials used for the care of the patient should be handled in the same manner.

D. C. BLOEMENDAAL, M.D. (Ottawa): I would like to ask one question. It seems to me that since this rebate is out, the cost to the patient is going to be greater than before. If the cost to the patient, say, was $15, that cost is going to be $25 now. I mean just to make the statement. I don't know. I would like to have Dr. Pino give his opinion on this, whether this will increase the cost to the patient or whether it will cut down the cost to the patient.

THE VICE SPEAKER: Dr. Pino, will you answer the question?

R. H. PINO, M.D. (Wayne): Mr. Speaker, I think it is admitted by the Better Business Bureau and by the Wayne County Medical Society, in their consideration of this problem, that the cost to the patient will not be less.

Already the doctors are raising the price of their examination;

that is, some of the people are. They are trying to do it in this way. They are trying to send with their prescription a notice to the company to charge the patient a certain discount, to see if they can't balance it. If that could be carried out completely, it might work, but you see what the newspapers print. The public believes what it reads, and it reads in the newspapers and on the windows and everywhere, "Come to me. Come to the basement store. Come anywhere." They hear it on the radio. "You can get your glasses cheaper," and so on. Consequently they go out to these places.

An examination—I think this is appropos—of 1,000 patients in the City of Cleveland revealed that for that part of the examination that the optometrist gives, which is the refraction only, as compared with the complete examination given by the Doctor of Medicine, the whole package of the eye care, the glasses and examination cost $1.96 more than the same thing does from the ophthalmologist. So the commercial aspect of it makes the cost ultimately more.

You have heard so much about California and what the Better Business Bureau has done for them out there. One of our men went out there, and the other day in Los Angeles he had a pair of these trifocal lenses. They are more expensive. There are three parts. So he went to get some new ones, and the price was exactly the same as he charges in his own office where he does his own dispensing.

Oh, gentlemen, there is no saving to the public, which is what Dr. Don Campbell, Dr. George Frothingham, Dr. J. M. Robb and all these men have contended all along. The only man that stands between the patient and the outside interests is the Doctor of Medicine, for the American Optical Company and some of the others—and I can name them to you, nine different concerns here in Detroit—are striving to get the business there.

It just takes it out of the doctor's hands. That is all. I don't know whether that answers your question.

D. C. Bloemendaal, M.D. (Ottawa): Yes, it does. You see, the cost is higher.

The Vice Speaker: Is there any other discussion?

H. L. Morris, M.D. (Detroit): I have listened with a great deal of interest to Dr. Pino's discussion. I am reminded that Dr. Long years ago, about 1900, stated and proved adequately by photography and clinical histories, that nephroptosis was the cause of a great deal of urinary tract disorders, abdominal disorders, ovarian disorders, and chest disorders, and what have you.

Dr. Pino has given us something to think about. I am not an official spokesman for the Urological Society, but it strikes me, as being an urologist in Michigan, that we as urologists have missed a big opportunity over a period of years, since Dr. Long wrote his book. Less than one per cent of our people that we see with nephroptosis require nephorpexy, according to our present technique and diagnosis. The consequence is that those people are relieved by various kinds of supports and medical and internal treatment of one kind and another.

I think Dr. Pino really has something, because if it is good for the ophthalmologist to get a rake-off on this particular type of appliance that they use on the eyes, I think that Crowley & Milner and the rest of them should have urological departments, where they can make pyelograms and do similar things, and turn over a rebate to us.

They don't do that at Miller's and Crowley & Milner, and Hudson's and other stores, but it is a good idea. I am for it. Over a long period of time I know I have been prescribing these various and sundry supports for the nephroptosis which appears in these people over a long period of time for the relief of their upper urinary tract distress, and I have gotten no rebate. I offer this as a suggestion to the House of Delegates, that this probably is a good idea. If you can get a couple of dollars extra, I for one will subscribe to a urological department in Crowley & Milner's and Hudson's and other department stores, where they can cystoscope them and catheterize the ureters and charge them $3 for the examination and then get a rebate from the store. It is just as logical a conclusion to assume that you are going to get a $3 examination and then get something that you get out of the business.

If the doctor's opinion is worth anything, if it is only worth $3, for God's sake let him be satisfied with $3. If he thinks he can fit a pair of glasses or examine a pair of eyes and it is worth $25, let him charge that $25. If the urologist only evaluates his diagnostic ability at three dollars, let him catheterize the ureters and do the cystoscopy and make the pyelogram and charge $3, and get $10 for the belt he prescribes.

I think Dr. Pino really has something. Mr. Speaker and the House of Delegates: I really am sincere about this. I have been overlooking a bet for a good many years. I am not speaking officially for the Urological Society, but I think the urologists in the house will agree with me that we have been overlooking the rebate from the appliances we apply every day, for which we have not overcharged our patients.

The Vice Speaker: Any other discussion?

T. H. Pauli, M.D. (Oakland): I am of the opinion, gentlemen, that we are talking round and round a circle. We are cutting the issue. We are talking about rebates. Are they right or are they wrong? If they are wrong, let's not pussyfoot. It looks to me as though 100 of us are sitting here pussyfooting. We have a lobbyist who is very well trained, and I don't think he should get your attention away from the fundamental issue: Is we is, or is we ain't?

It is either right or it is wrong. As I understood the refined amendment, we thought it was wrong and we were no longer going to continue, but we did condone.

I don't think that any loophole should be left as to how we stand, and I think that if we approve the proposal, we are condoning it.

I have no objection to a man's charging a just fee. I don't believe anyone has. I don't see why we should in any way, shape, form or manner condone anything that smells of rebate. On the other hand, I do agree that the ophthalmologists are, as a rule, high-minded, and they are ethical. I think it is up to them to clean their own house. I think it is up to us certainly to help them.

I would criticize the AMA if it came out and left them on a limb. It is not particularly a fortunate spot to be on. I don't feel that we can afford to pussyfoot. Pussyfooting probably is not in the dictionary, but I think you all know what I mean. I am very definitely against anything but a frank statement that we are opposed to rebates in all ways, shapes or form or manner, and I am perfectly willing to allow that to have to do with the penicillin charge or what have you.

I don't think the question of rebates has anything to do with the cost of refraction. Indirectly it may have something to do with the quality of medical care. That is not the question. The question is: Is it right, or is it wrong? If you will just keep your mind on those two little words, that is all you need.

R. H. Pino, M.D. (Wayne): Mr. Speaker, the subject of rebates is by the board. That is being taken care of by the Federal Government, and it is being taken care of by many of us who are working on this problem and have been for a long time. We believe we see ways and means of handling it. But whether we do or not, rebates are out, and as I understand the resolution that was brought in, it isn't condoning rebates or anything else.

Here is what I would like to ask the doctor who just spoke. What is—well, I don't care what your specialty is.

T. H. Pauli, M.D. (Oakland): There isn't any.

R. H. Pino, M.D. (Wayne): You have no specialty. All right then, I might ask the question: Are you in general practice?

T. H. Pauli, M.D. (Oakland): That is right.

R. H. Pino, M.D. (Wayne): In Detroit?

T. H. Pauli, M.D. (Oakland): In Pontiac.

R. H. Pino, M.D. (Wayne): Do you prescribe? Do you take care of only patients who are well-to-do?

T. H. Pauli, M.D. (Oakland): Definitely not.

R. H. Pino, M.D. (Wayne): You have them all the way from nothing up?

T. H. Pauli, M.D. (Oakland): That is right.

C. J. Barone, M.D. (Wayne): Point of order, Mr. Speaker. This conversation should be directed to the speaker and not across the floor.

The Vice Speaker: I think you are quite correct. The Chair feels that personalities should not enter into this. Dr. Pino will confine himself to generalities.

R. H. Pino, M.D. (Wayne): Let us say this. The resolution, as I understand it, states merely that it is proper for the ophthalmologist to handle glasses. It makes it possible.

Now what I am thinking is this. Let's take my own office and that of many others. I do take care of people, charging from nothing up to whatever is reasonable. Unlike giving a hypodermic injection from an ampule, I am responsible for an apparatus that one wears on her face, that relieves or does not relieve symptoms. If the patient cannot wear that glass that I prescribe, I am still responsible, to change those glasses as many times as indicated. It is something quite different than simply prescribing glasses.

I understand this resolution is such—Can I do that in my office, or shall I have to give a prescription and send it outside? If I subscribe, let us say, let's bring it back to this. We prescribe, and instead of putting the patient to the bother of going to the drug store for something, and maybe having to pay large prices for it, we have it there handy. We give certain ointments that are hard to get. We may give them away as a part of the package of eye care, or we may charge a little for them. I think that this makes that possible.

Dr. Morris—I don't know whether he was just joking or not. I don't know what it is you prescribe that they might buy somewhere. If you are thinking in terms that you are getting a rebate on what you prescribe, we are getting away with rebates. I have tried to use myself as an example, and the rest of them, but up to the present time we have had no way of handling it. The great optical companies and the Federal Government had no way of handling it. We were almost in between, trying to regulate this thing, and if we would charge everybody a large price and they would go out and pay the large price for glasses, it would certainly be hard on them financially.

I don't believe I quite understood Dr. Morris. I don't know if that explains it.

S. W. Insley, M.D. (Wayne): Mr. Speaker and Fellow Members: I am not so sure that I understand all of the arguments myself.

I might point out that I may be younger than any of the other men in the hall tonight, but after all I have spent exactly twenty years in this House of Delegates, and I have yet to hear in any time in those twenty years a series of arguments that had more circumlocution.

I could say, let's get back to the original motion. I am in favor of it, and I will call for the question.

The Vice Speaker: Are you ready for the question, gentlemen?

H. L. Morris, M.D. (Wayne): What is the question?

The Vice Speaker: Do you want the resolution read again, or the whole preamble?

R. S. Breakey, M.D. (Ingham): Not the preamble.

The Vice Speaker: Just the resolution. Not the whereases.

Douglas Donald, M.D. (Wayne): "Be it therefore resolved:

"*That* It is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"*That* We urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

The Vice Speaker: Thank you. You have heard the resolution.

Are you ready for a vote? All in favor say "aye"; opposed. Will those opposed please raise their hands? Those in favor of it. The motion is carried.

Dr. Donald has one more matter.

XII—h. ACS HOSPITAL STANDARDS

DOUGLAS DONALD, M.D. (Wayne): The second resolution presented to this Committee was presented by Dr. Harm yesterday. I will read the resolution.

"WHEREAS, The Michigan State Medical Society feels that it is the governing body in the State of Michigan for its own members;

"WHEREAS, The Michigan State Medical Society through its county and state Ethics Committees has the authority and means of disciplining its members; and

"WHEREAS, The American College of Surgeons through its inspection of hospitals insinuated that some members of the Michigan State Medical Society were guilty of unethical practices without submitting any proof of these deeds; and

"WHEREAS, The American College of Surgeons insisted that hospital superintendents discipline members of their staffs and force their members to sign pledges laid down by the American College of Surgeons for their own members; and

"WHEREAS, The vast majority of the members of the Michigan State Medical Society are not members of the American College of Surgeons and therefore should not be subject to its rules and regulations in any manner; and

"WHEREAS, The American Medical Association has always recognized the county society as the interpreter locally of the Code of Ethics of the American Medical Association; therefore, be it

"RESOLVED, That the Michigan State Medical Society notify the American College of Surgeons that any infractions in ethics by Michigan State Medical Society members with proof of such infractions hereafter be submitted to the Ethics Committee of their county society or of the state society for discipline rather than to superintendents of hospitals, lay or otherwise; and be it further

"RESOLVED, That the Michigan State Medical Society request the American Medical Association to assume the approval of hospitals for the training of interns and residents and that approval of such hospitals and such training be entirely independent of any approval or disapproval by the American College of Surgeons or any other specialized organization."

This resolution came up for discussion and was widely discussed, not only by the Committee but by members of the House of Delegates, who joined in our discussion.

The Committee recommends the rejection of the resolution as worded, although some of the principles contained herein are worthy of further study, and we recommend that this be referred to The Council for further consideration.

Mr. Speaker, I move that the report of the Committee be adopted.

H. W. WILEY, M.D. (Ingham): I second the motion.

THE VICE SPEAKER: You have heard the motion and the support. The recommendation of the Committee is that it be referred to The Council. Is there any discussion?

H. L. MORRIS, M.D. (Wayne): I would like to ask Dr. Donald to state to the assembly what the statutes of the State of Michigan are relative to this particular matter.

THE VICE SPEAKER: Dr. Donald.

DOUGLAS DONALD, M.D. (Wayne): As a matter of fact, Dr. Morris, I will ask you to state that. I don't know what you are speaking of.

H. L. MORRIS, M.D. (Wayne): Mr. Speaker, quite evidently this motion has to deal with the ruling of the American College of Surgeons relative to splitting the fees, which every physician in recognized hospitals is requested to sign by the superintendent of the hospital, in which he works, pledging his allegiance to the nonsplitting of fees.

There is a statute in the books of the State of Michigan, enacted by our legislative body some twenty-odd years ago, which states very emphatically and specifically that there is to be no division of fees or splitting of fees, which is a thing which I think most of us do not know about.

Now if that is so, and I know that it is because I have read the Act—Can you give me the exact date of that? It was some fifteen or twenty years ago that that legislation was enacted in this state, and very properly. It is on our books of legislation in this state, so that the question which Dr. Harm raises is not a question of the A.C.S. or any other governing body. It is a standing order and rule and legislative action by the legislative body in this state.

J. J. O'MEARA, M.D. (Jackson): That was 1915.

H. L. MORRIS, M.D. (Wayne): Well, 1919. I will admit a couple of years difference.

W. B. HARM, M.D. (Wayne): Both in the Committee and as you heard here tonight, the way it was expressed was that it was my resolution. It seems to be brought out that this is a personal grievance of mine.

There is a principle here. Dr. Morris has made the statement that I am objecting to a ruling on the splitting of fees. There is nothing in this resolution that says anything about splitting of fees, and if he is a wizard as a lawyer, I would like to have him define what is splitting of fees.

This question came up when the examiner of the American College of Surgeons entered several of our hospitals. In going through the hospitals, he noted that two men were at the operating table. In some cases it was a general practitioner assisting a surgeon. In another case, in one particular hospital, it was a young man with three years of residence training in surgery, who was doing an operation that he had not done too many times, and he asked one of the senior surgeons to step in and stand by while he was doing it, which I think was very creditable of the young man to do.

Two men being at the operating table, the inspector inferred that the case was being split, and without making any more inquiries, he accused the staff, the entire staff, of various hospitals of being unethical.

It is not unethical to share a case. I think you will all admit that. The unethical part of it seems to be the splitting of fees. I don't know the answer to that.

However, the American College of Surgeons took it upon themselves to reprimand the whole staff of these hospitals through the hospital superintendent, without ever supplying proof that these men had done anything unethical, and they managed to do it because of the fact of their control over hospitals through the approval of residents. Remember that when they withdraw their approval on residencies, they do not withdraw the approval of the residencies for surgery; they withdraw the approval for pediatrics, for urology, Dr. Morris, for radiology. They withdraw all residents approvals.

The hospital superintendents go by the bible as written by the American College of Surgeons, called the Manual.

The thing that one of the staffs in this city was asked to sign was not the pledge. We have all signed that pledge. It is part of your hospital application. But they set on it the bottom half of one of the pages in the American College of Surgeons' Manual, in which there is no pledge. There is nothing said about it, that you must do it or you will do it. All it is is a statement of what should happen. It includes that a separate bill should be sent out; that the general practitioner should not assume a place at the operating table, which in my opinion is the result they were after on this case to exclude the general man and the nonspecialized surgeon from the operating room, that he shouldn't be there at the table because of the fact that that place at the table belongs to the first resident and there is another place for the second, and then the third. I don't know how you number them. I said to the Committee last night, "Somebody better grab it whether he is first, second or third."

Through that method they have obtained control over the whole hospital staff, not only their own surgeons but the general men, the internists, the urologist, the radiologist, the o.b. men.

They put out this Manual, and the Manual is divided on what each department should have. One pathologist the other day said the inspector walked into his pathological laboratory and told him he had to many books there, that he shouldn't have books in his laboratory; they should be down in the library. That is just one of the little things that happen.

It is my opinion that the American College of Surgeons has no right to ask the nonmembers of their organization to sign anything for them. I will willingly abide by the rules laid down by my hospital. I will abide by the rules laid down by the county medical society, the state medical society or the American Medical Association, because they represent a group who are all doctors, not only some. We should be controlled by our main group. There is no reason for the American College of Surgeons to step in and tell all of us what to do. They did not attempt in this case to go out and reprimand their own members who are members of the hospital staff. That would be starting out with their own members and bringing them into the light. They didn't dare do that. So they picked on everybody. Then their members didn't shine, but if there was any unethical practice, in order to have it occur under the circumstances, their own members were guilty just as well as anybody else. But they did not attempt to put the reprimand on their own members but included everybody in the hospital, and they included them from the top, from our consulting and retired staff on down to the courtesy staff.

In the Committee room mention was made that this had happened in Detroit. There is still a principle behind it. Under the Hill-Burton Act, you are going to have hospitals all over this state. You are going to have them regulated, and you fellows out in the states are going to be up against the same thing we are here, and the same thing can happen to you, if the continuation of such occurrences is going to disrupt the medical profession. It is a peculiar thing that these occurrences, particularly in Detroit, happened in hospitals with general practice sections. I make no accusation there, but it did occur.

Now, gentlemen, it is my feeling that I am willing to submit to any rules and regulations for organized medicine, but if I have to obey, in addition, the rules of each specific group, the American College of Surgeons, next week the American College of Physicians may make out rules, and the pathologists may, the radiologists may, and maybe the general practitioners will, and you are going to have

so many rules and regulations nobody can follow them, and no one can abide by them.

The second part of this resolution has already been approved by your House of Delegates of the American Medical Association, and they are already preparing to take over the approval of hospitals, the approval of training for internships and the approval of training for residencies. They have already done it to a great extent in their Boards. These same hospitals that the College of Surgeons is taking away the privileges and residencies, are still recognized for residencies by Boards.

But, gentlemen, if I have to abide by the rules and regulations of all these higher bureaucrats of our profession, then it is my sincere believe that I am ready to go for federalized medicine, where we will have laws and rules and regulations that are jammed down our throats by politicians, but at least we will have only one set to follow. Thank you. (Applause)

L. W. GERSTNER, M.D. (Kalamazoo): Mr. Speaker, certainly now is the time for the men around the state to assert themselves. I know many of us are in sympathy with the view that has just been stated.

Secondly, certainly putting this in the lap of The Council will not settle it. It should be settled by the men in the state who are represented here.

I hope that the motion to have this placed in the hands of The Council will not pass. I further hope that the recommendation of the Committee will not pass. I think that this is something that we should very carefully consider and discuss by members throughout the state.

H. H. RIECKER, M.D. (Washtenaw): Mr. Speaker and Members: I move an amendment to Dr. Donald's Committee report, deleting the words "and be referred to The Council for decision."

Thank you.

THE VICE SPEAKER: Before I ask for a second to that, may I just read the last line of this?

"The Committee recommends the rejection of the resolution as worded, although some of the principles contained herein are worthy of further study, and we recommend that this be referred to The Council for further consideration."

I understand Dr. Riecker's amendment is to omit reference to The Council. Is that correct?

H. H. RIECKER, M.D. (Washtenaw): That is correct. I didn't have the exact wording.

R. A. SPRINGER, M.D. (St. Joseph): I second the amendment.

THE VICE SPEAKER: The amendment is seconded.

C. J. BARONE, M.D. (Wayne): I am like many others in this audience in regard to being a poor speaker. I want you to consider the fact that many places in the City of Detroit, in Wayne County, in the State of Michigan, the general practitioner is not allowed to go into hospitals—not all hospitals but a great many of them have that ruling.

The American College of Surgeons, about a year or two years ago stated in its booklet that the governing board of each hospital shall determine the rules and regulations that shall be carried out for that hospital. Now we find that the American College of Surgeons is entering the various hospitals in this state and frowning upon those hospitals that have general practice sections.

It is my firm belief that if the practice of medicine, as we know it, is to survive we have a great deal of need for general practitioners, more than we have for specialists. The specialists cannot survive, nor can they keep their hospitals full of patients unless the general practitioner refers the patients to them.

One other point. I know many internists. I know many specialists, board members, College of Surgeons, or what have you, who when it comes to making a night call refuse to make it. They expect the general practitioner to go out, give the patient a quarter of a grain of morphine or whatever you want, and immediately refer the patient then, who probably needs hospital care, and take him immediately to the admitting clerk and say to this patient, "I want to thank you for allowing me to take care of you at the time of your need, but now you are in a specialists' hospital where the Lord knows what will happen to you. But if you get out alive, come back to me, and I will take care of you, either in my office or in your home."

Another point I would like to make is simply this, that in order to become a member of the American College of Surgeons in some instances all you have to do is know the members of the American College of Surgeons in your neighborhood who are friends of yours and write up about 100 histories, or whatever the number is, present them, and you will be accepted.

Gentlemen, if that is not happening today, I can take you back to three or four years ago, and I could state the name of a man who was accepted under those circumstances. He did not have 80 or 85 per cent surgical cases in his practice, nor did he have 80 or 85 per cent surgical cases in the hospital that he did his major work in. He had a grand sum of 35 per cent of surgical cases, and the rest of them were equally divided among the other specialties.

Now I was told when I brought this to the attention of a noted member of the American College, that under those circumstances he wouldn't have got his F.A.C.S., and I asked him if somebody lied in regard to the matter.

Gentlemen, I do not think that this matter that is before this body today should be left in the air. I think we should have backbone enough in this House of Delegates to either pass that or turn it down. I thank you.

THE VICE SPEAKER: Any further discussion?

R. W. TEED, M.D. (Washtenaw): Mr. Speaker—

THE VICE SPEAKER: We have a motion, gentlemen, and a motion to amend. Will you try to confine your main discussion of the moment to the question of the amendment, which pertains to referring the question to The Council? I don't want to cut off discussion on the whole subject, but try to take things in order, gentlemen.

R. W. TEED, M.D. (Washtenaw): Mr. Chairman and Gentlemen of the House: I would like to say, first, that I am a member of the American College of Surgeons. Twelve years ago, when I joined the organization, there was agreement that I would pay $500 over a period of twenty years, and that would constitute the financial part of the fellowship. Last January I got a statement to the effect that the dues for the fellowship were now $1000 and I should pay up.

I submit, gentlemen, that an organization which has no more morality regarding its own agreement has very little right to talk to another man regarding morality in his practice, particularly when, as Dr. Harm says, it has not been proven.

I, therefore, suggest, or submit that this amendment be turned down and that the House pass action on this question.

T. P. WICKLIFFE, M.D. (Houghton): I am not from Wayne County. I am from the Upper Peninsula. I am a general practitioner and have practiced for thirty years. I do general surgery. I do obstetrics, gynecology and pediatrics. I practice in a small hospital.

I still think we should have some governing board to govern the practice of some doctors. I have a young son who has finished one year in medicine, starting on his second year, and I hope that if I am not alive, that somebody will be around to direct him in the right channels to practice good, ethical medicine.

Notwithstanding the fact that I am not a member of the College of Surgeons—and I would like to be if I could qualify—I am sorry to hear this gentleman who preceded me talk the way he did. If I had accepted membership in the American College of Surgeons, I would not say what he said. I still think that somebody has got to regulate a great many of us doctors. In my own small town, in my own small county, we need a hell of a lot of regulations. Thank you. (Applause)

THE VICE SPEAKER: Any other discussion?

WILLIAM BROMME, M.D. (Wayne): My few remarks are not about the matter at hand, but simply to make an explanation about the fees. I became a member of the College of Surgeons in 1939, and I was told at that time that life membership dues were a certain sum. In January of 1940 I received a note, announcing that by virtue of an action by the Board of Governors, the life membership fee would be doubled by a given date, but if my life membership was paid in full by 1949, my life membership fee would be thus and so.

I think that is what the speaker was referring to. If one paid up his life membership dues at a given time, he would not be subject to the increase in dues. That is certainly true in the figures I got.

THE VICE SPEAKER: Any other discussion?

H. H. RIECKER, M.D. (Washtenaw): Will you clarify my motion?

THE VICE SPEAKER: I understand your motion, Dr. Riecker, it is to omit the portion of the recommendation from the Reference Committee which would refer this matter to The Council for consideration and recommendation.

(Calls for the question.)

Are you ready for a vote on the amendment, not to refer this? All in favor of not referring this to The Council, please say "aye"; all those opposed, in other words, to refer it to The Council. Those in favor of not referring, please raise their hands. The Chair rules that the motion not to refer was carried, so the motion as amended is before us. Will you read that, Dr. Donald, as it would be amended?

DOUGLAS DONALD, M.D. (Wayne): The motion as amended would read as follows:

"The Committee recommends the rejection of the resolution as worded, although some of the principles contained herein are worthy of further study."

THE VICE SPEAKER: That would be the motion then, because the amendment has stricken out the last portion. Are you ready to vote on that motion?

W. W. BABCOCK, M.D. (Wayne): Gentlemen, I am sorry to prolong this further, but I feel I must point out what I think is right and what I think is wrong.

In the first place, I am a member of the American College of Surgeons, and I wish to substantiate what Dr. Bromme stated to you. We were allowed to pay up our $500 fee if it had not been paid, without having to pay the excess, if we did it within a certain amount of time. I personally felt no resentment at that.

When I learned my surgery I learned that under the preceptor method, and gentlemen, I tried not to, but I know I buried some of my mistakes.

I cannot help but feel, having learned by the preceptor method —and I feel that I had a good preceptor—that the training of surgeons by the residency rule is preferable, that we are putting out better surgeons, and I cannot help but feel that the American College of Surgeons has contributed tremendously to the advancement of surgical care and practice. I sincerely feel that, though I myself was never a surgical resident.

That being the case, if we disfranchise the American College of Surgeons from the control of surgery in our hospitals, I can't help but feel that we will be taking a step backward. We are referring the control of surgery to the AMA. and they will have to learn, and it will take many, many years before a smooth-running organization as we now have could control the proper type of surgery in our hospitals.

I do sincerely feel that Dr. Harm has some valid objections. I cannot blame any man, particularly one who is not a surgeon, for resenting the fact that he must sign when he attends a staff meeting. We are being regimented. I can't blame Dr. Harm for resenting the fact, because I know he is a busy man, that he is called on at many hours, that without a valid excuse he will be expelled from the staff if he does not attend three-quarters of the staff meetings, but that is a point that is beside the point when it comes to the control of surgery as practiced in our larger hospitals.

THE VICE SPEAKER: Any other discussion?

B. T. MONTGOMERY, M.D. (Chippewa-Mackinac): I am not a member of the American College of Surgeons. I am a general practitioner, but I think what we need in medicine is more honesty among the general practitioners and among the surgeons.

I think that the general practitioner doesn't get probably his fair share. This splitting of fees is difficult. The case is worked up, main diagnosis made, and turned in to the hospital, to the surgeon for operation. I have had special training in surgery, and I was a resident surgeon, but when I went to Sault I found that in order to make a living I had to do general practice, and that is what I am doing. So I have the general practitioner's viewpoint when it comes to making a living, but I also think that we ought to raise our standards in all of our hospitals on the level of diagnosis. We should operate for a definite reason, rather than for the one hundred bucks the patient may have in his pocket. In order to keep surgery on that level, we have to have some control, because we are all human and humans were born to err, especially when it comes to money.

I think that we should still have the American College of Surgeons or some like body to attempt to keep what I call carpenter surgeons from operating unnecessarily. I know of plenty of operations that are done for patients, displaced uterus, and we call that the passion operation in our hospital, and I know plenty of patients that go to the operating room that have a so-called chronic appendix removed and sometimes they drag the operating room team out at midnight because they don't know when they will be able to work the operation in otherwise, so they make it an emergency.

Personally, I think we should get back and get a little bit more religion into our lives when we are practicing medicine.

H. H. RIECKER, M.D. (Washtenaw): Will the Chair state the motion?

THE VICE SPEAKER: The Reference Committee moves, and Dr. Donald read it. Do you want it read again?

(Calls for the question).

Are you ready for the vote?

W. B. HARM, M.D. (Wayne): May I have the question?

THE VICE SPEAKER: Just a moment. There is a question on the floor. I will try to answer it. You have heard the resolution read. You heard the report from the Reference Committee, and then the motion from the Reference Committee. That is what you are voting on. This motion reads as follows:

"The Committee recommends the rejection of the resolution as worded although some of the principles contained herein are worthy of further study."

That is the motion on which you are voting now, the motion as amended.

W. B. HARM, M.D. (Wayne): May I ask a question?

THE VICE SPEAKER: Yes.

W. B. HARM, M.D. (Wayne): If this motion is turned down, will there then be a vote on the original resolution?

THE VICE SPEAKER: If the motion is turned down, the resolution is before the House for disposition, the original resolution.

All in favor of this motion of the Reference Committee say "aye"; opposed.

H. L. MORRIS, M.D. (Wayne): What is the original, Mr. Speaker?

THE VICE SPEAKER: This is the motion. There is no original motion. There is only one motion before the House. The resolution that Dr. Harm presented was referred to the Committee.

W. B. HARM, M.D. (Wayne): Dr. Harm just asked the question.

THE VICE SPEAKER: It is a motion to reject. Will you please stand? Those who are in favor of rejecting the resolution.

W. B. HARM, M.D. (Wayne): Is that rejecting the resolution or favoring the Committee's report?

THE VICE SPEAKER: The motion is to reject the original resolution. That is the motion of the Reference Committee. That is what you are voting on.

Will you gentlemen be seated, and those who are opposed to the motion which would reject the resolution stand. Do you understand what you are voting on?

DELEGATES: No.

W. B. HARM, M.D. (Wayne): Not the way you are stating it.

THE VICE SPEAKER: Those who are voting in opposition to this motion from the Reference Committee now would be tantamount to wishing to vote on the original resolution. Is that clear?

Do you know what you are voting on?

DELEGATES: No.

THE VICE SPEAKER: I will state it again. Dr. Harm brought in a resolution to this House, which was referred by the Speaker to the Reference Committee. The Reference Committee came back to you with a refusal of the resolution, recommending that it be not accepted. Part of their motion was deleted. We have taken one vote on this refusal. Now I ask for the negative vote, which denies their refusal or gives us an opportunity to vote again or reconsider the resolution presented by Dr. Harm.

W. B. HARM, M.D. (Wayne): Mr. Chairman, I rise to a point of order. I think the Chair has balled up the entire voting on this motion. He should put it either to accept the recommendation of the Committee or not to accept it. For that reason I ask for a re-vote.

THE VICE SPEAKER: All right, Dr. Harm, I will accept that suggestion. I will ask for the affirmative vote accepting the recommendation of the Committee. Those in favor of accepting the recommendation of the Committee please stand.

S. L. LOUPEE, M.D. (Cass): Mr. Chairman, are those recommendations amended?

THE VICE SPEAKER: Yes, they have been amended.

S. L. LOUPEE, M.D. (Cass): The motion carries the amendment. That has been passed. What we are voting on is amended. Then if you approve it, the whole thing dies.

THE VICE SPEAKER: Right. Will you be seated, and those wishing to reject the Committee's report please stand? The motion supporting the Committee's recommendation is carried.

Dr. Donald, do you have anything else?

DOUGLAS DONALD, M.D. (Wayne): Nothing more to bring before the House.

Mr. Speaker, I move the acceptance of the whole report of the Committee on Ethics.

(The motion was seconded.)

THE VICE SPEAKER: It is moved and seconded to accept the report of the Committee on Ethics. Any discussion? If not, all in favor say "aye"; opposed. Carried.

Now we still have some business, a supplementary report from The Council. Dr. Beck!

XII—b. ON REPORTS OF THE COUNCIL

O. O. BECK, M.D.: Mr. Speaker and Delegates: This pertains to a motion adopted by The Council at special session this afternoon, and it is referred to the House of Delegates.

First, that the Seventeenth and Eighteenth Councilor Districts be added from Wayne County, the term of the Councilor from the Seventeenth District to expire in 1949 and the term of the Councilor from the Eighteenth District to expire in 1953.

Second, inasmuch as we do not have sufficient data on boundary lines at the present time or mechanism for nominating by districts in Wayne County, The Council recommends that nominations for the two new Councilors be made by the Wayne County Delegation and that Wayne County be authorized to make boundary divisions and report to The Council prior to the next meeting of the House of Delegates.

THE VICE SPEAKER: You have heard the motion that Dr. Beck has presented from The Council. Is there a second?

R. S. BREAKEY, M.D. (Ingham): I move the adoption of The Council's supplementary report.

THE VICE SPEAKER: We have a motion from Dr. Breakey for the adoption of The Council's supplementary report. Is there a second?

E. G. KRIEG, M.D. (Wayne): I second it.

THE VICE SPEAKER: Any discussion?

If not, all in favor say "aye"; opposed. It is carried.

Are there any further reports from any Reference Committees?

C. L. WESTON, M.D. (Shiawassee): I have a brief report from the Reference Committee on Reports of The Council.

Mr. Speaker and Delegates of the House: You will recall that in the previous report of the Reference Committee on Reports of The Council a question was raised by the Committee, asking if The Council could explain to us why the interest on eighty-four thousand dollars worth of bonds for a year amounted to only $346. The Committee would like at this time, if Dr. Brunk is present, to have him give lucid explanation, which I think he can do easily. Is Dr. Brunk here?

THE VICE SPEAKER: Dr. Brunk will attempt to answer the question now.

A. S. BRUNK, M.D. (Wayne): Gentlemen, I don't think it would be very hard to answer why we have such a small return on our bonds. Inasmuch as the market has been rather unstable lately, we have confined our investments entirely to government bonds, and of course you know what the rate of interest is that the Government pays. Now your return is simply what the Government pays on Government bonds. The income as it accumulates and gets to be a sizable amount is reinvested and consequently we have very little balance on hand.

C. L. WESTON, M.D. (Shiawassee): I would say that as far as the Committee is concerned, that answers the question.

If there is no further discussion, that closes the report of the Committee. Thank you, Doctor.

THE VICE SPEAKER: Any other Reference Committees who have a supplemental report?

If not, I would like to turn the chair back to the Speaker.

(J. S. DeTar, M.D., the Speaker, resumed the chair.)

THE SPEAKER: We have only a few items left on the agenda.

I would like to ask the Committee on Credentials—Dr. O'Meara, Dr. Bailey and Dr. Harm—to escort all present ex-Presidents of the Society to the platform.

J. J. O'MEARA, M.D. (Jackson): May I have Dr. Gruber in Dr. Bailey's place?

THE SPEAKER: I think the exchange is probably in our favor. Will you please escort the ex-Presidents—Dr. A. S. Brunk, Dr. R. S. Morrish, Dr. Grover C. Penberthy, Dr. Henry A. Luce, Dr. Claude R. Keyport, Dr. L. J. Hirschman and Dr. Henry Cook to the platform?

There are plenty of chairs. Some of our ex-Presidents have grown heavier, but they are good chairs. So step right up, gentlemen. We would like to see what our ex-Presidents look like.

(The audience rose and applauded as the Past Presidents were escorted to the platform.)

THE SPEAKER: You have seen the working force on the platform all this time. Now here is the glamour. Welcome, gentlemen. We are glad to see you.

THE SPEAKER: I would like to ask the Committee on Credentials to bring President P. L. Ledwidge and President-Elect E. F. Sladek to the platform.

(The audience rose and applauded as Dr. Ledwidge and Dr. Sladek were escorted to the platform.)

THE SPEAKER: Here are your President and President-Elect. Welcome, gentlemen.

Don't go away, gentlemen. We are going to elect a few more.

I would like to ask Dr. Spalding, who is Chairman of the Reference Committee of Constitution and By-laws, to explain to us, before we proceed with the election of Councilors, what the Constitution

specifies concerning the election of the two new Councilors for the two new Councilor Districts. Dr. Spalding.

E. D. SPALDING, M.D. (Wayne): Gentlemen, after your forbearance this morning, I hoped I was going to get out of here permanently, but I promise that what I have to say will be very brief. It comes out of the fact that this House of Delegates today has granted Wayne's petition for two new Councilors by subdividing Wayne four ways, meaning two new Councilorships. There are four points.

In the first place, the basis on which this authority rests is as follows: If any of you have your mimeographed Constitution lying around, if you will turn to page 7, Chapter 8 of the By-laws and Section 3, under the heading of the House of Delegates, Section 3 of Chapter 8 specifically states that the House of Delegates, among other things, shall provide for the organization of Councilor Districts.

Secondly, on page 11, under Chapter 11, Section 1, the question of the terms of the Councilorships and their expiration dates—under Chapter 11, Section 1, among officers it says that the officers of the Society shall serve until the next Annual Session, provided that Councilors shall serve for five years, and provided, further, that not more than four Councilors' terms shall expire normally at any one annual session.

Obviously, to permit this to become effective, it is necessary to set up the rotation of your Councilorships, so that they will expire at certain times.

The third point is on page 8, Chapter 8, Section 10, subsection (g), under the House of Delegates, about the election of Councilors. Section 10 (g) says that the House of Delegates "shall elect the Councilors upon the nomination of the Delegates of the Councilor District whose Councilor's term expires."

Obviously, with the new Councilor Districts created, there is no term expiring, but a new term is being created, which is essentially the same thing.

Now, finally, in case there is any doubt in anybody's mind as to whether this is a proper thing that is being suggested, I would refer you to page 7, Section 10 of Chapter 8, under the House of Delegates, where it specifically says that "The House of Delegates is the legislative body of This State Society, and shall have authority to adopt and institute such methods and measures as it may deem most sufficient for the upbuilding and establishing of the interest of the profession in Michigan.

It is highly important for the interests of the profession in Michigan as a whole, and in Wayne County in particular, that these new Councilorships shall come in the general rotation already established.

On page 25 of your Handbook you have at the foot of the page the names of all of your Councilors and the dates of expiration, and you will note that in 1949 there is only one Councilorship that is terminated. All the rest have three or four terminations. Wayne, in its two present Councilors, has one that terminates in 1950 and in 1951. It is important that in the creation of these two new Districts we arrange that the Council shall have another Councilor whose term shall expire in this year, when only one Councilor is now to be lost, and another Councilor District coming over to the year 1953.

IX—s. MOTION SETTING TERMS OF COUNCILORS OF 17th & 18th DISTRICTS

In order to create this proper rotation of new Councilorships voted by the House of Delegates this afternoon, I move that the terms of rotation of the new Councilorships be so set that they will terminate for the new District No. 17 to terminate in the year 1953, and the new District No. 18 to terminate in the year 1949, which only has one Councilorship terminating in that year.

I so move.

THE SPEAKER: Is that motion seconded?

F. A. WEISER, M.D. (Wayne): I second it.

THE SPEAKER: You have heard the motion, and it has been supported. Is there any discussion?

If not, all in favor signify by saying "aye"; opposed "no." The motion is passed.

XIII—Election of Officers

The next order of business is the election of a Councilor from the Eleventh District, the incumbent of which is R. H. Holmes, M.D., of Muskegon.

Before I declare the floor open for nominations, I should like to appoint as tellers Dr. Breakey of Ingham as Chairman, Dr. Springer from St. Joseph, Dr. Teed of Washtenaw, Dr. Wickcliffe of Houghton, Dr. Ho of Clinton and Dr. M. H. Miller of Wayne. Will the tellers meet Dr. Breakey in the back of the house and decide how to get through with this?

XIII—a. COUNCILOR—11th DISTRICT

The Chair declares the nominations are open for Councilor of the Eleventh District.

T. J. KANE, M.D. (Muskegon): I wish to nominate Dr. Charlie Paukstis of Ludington for the Eleventh District Councilor.

THE SPEAKER: Dr. Charles Paukstis has been nominated for the position of Councilor of the Eleventh District. Are there other nominations?

Nominations should be made by delegates from that district.

R. D. RISK, M.D. (Muskegon): I move that the nominations be closed.

THE SPEAKER: It is moved that the nominations be closed. Is that motion supported?

E. G. KRIEG, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." The motion is passed and Dr. Charles Paukstis is automatically elected by a viva voce vote of the House.

The Constitution provides that we must vote by ballot unless there is only one nominee for the position.

XIII—b. COUNCILOR—12th DISTRICT

The next order of business is the election of a Councilor from the Twelfth District, Dr. A. H. Miller of Gladstone, incumbent.

W. A. LEMIRE, M.D. (Delta-Schoolcraft): I would like to nominate Dr. A. H. Miller of Gladstone as Councilor of the Twelfth District.

THE SPEAKER: Dr. A. H. Miller has been nominated to succeed himself.

B. T. MONTGOMERY, M.D. (Chippewa-Mackinac): I second the nomination.

THE SPEAKER: Are there any other nominations?

B. T. MONTGOMERY, M.D. (Chippewa-Mackinac): I move that the nominations be closed.

(The motion was seconded.)

THE SPEAKER: The motion has been seconded. Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed and Dr. A. H. Miller has been elected to the Councilorship to succeed himself in the Twelfth District.

XIII—c. COUNCILOR—13th DISTRICT

The floor is now open for nominations for the Councilorship of the Thirteenth District, W. H. Huron, incumbent.

D. R. SMITH, M.D. (Dickinson-Iron): Mr. Speaker, I wish to nominate Dr. W. S. Jones of Menominee County for the Thirteenth District.

T. P. WICKLIFFE, M.D. (Houghton): I second the nomination.

THE SPEAKER: Dr. W. S. Jones has been placed in nomination for this position. Are there any further nominations?

T. P. WICKLIFFE, M.D. (Houghton): I move the nominations be closed.

H. L. MORRIS, M.D. (Wayne): I second the motion.

THE SPEAKER: It is moved and seconded that nominations be closed. Is there any discussion? If not, those in favor say "aye"; opposed, "no." The motion is passed and Dr. Jones is elected to this Councilorship.

XIII—d. COUNCILOR—17th DISTRICT

Nominations are now open for the Councilorship of the Seventeenth District, the new Wayne District, with term ending in 1953. Nominations are now open.

C. K. HASLEY, M.D. (Wayne): I should like to propose the name of an ex-president of Wayne County, and when I state the name, you will all realize that he has done a whole lot for the General Practice group, nationally and locally. I would like to nominate W. B. Harm as Councilor of the Seventeenth District.

H. L. MORRIS, M.D. (Wayne): I move the nominations be closed.

C. I. OWEN, M.D. (Wayne): I second the motion.

THE SPEAKER: The motion that the nominations be closed has been seconded. Is there any discussion? All in favor say "aye"; opposed, "no." The motion is passed.

XIII—e. COUNCILOR—18th DISTRICT

THE SPEAKER: The next order of business is the selection of a Councilor for the Eighteenth District, of Detroit, with the term to end in 1949, a one-year term.

D. C. BEAVER, M.D. (Wayne): I would like to nominate Dr. William Bromme to represent Wayne in the Eighteenth District. You will recall that Dr. Bromme was the Chairman of the Reference Committee on Resolutions and you have heard him several times in the last few days.

THE SPEAKER: The name of Dr. Bromme has been placed in nomination for Councilor of the Eighteenth District. Are there other nominations?

J. J. LIGHTBODY, M.D. (Wayne): I move that the nominations be closed.

E. G. KRIEG, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? If not, those in favor say "aye"; opposed, "no." The motion is passed and Dr. Bromme is elected Councilor of the Eighteenth District.

XIII—f. DELEGATES TO AMA

The next order of business is the election of Delegates to the American Medical Association. If you will consult page 11 of your Handbook, you will discover that Dr. Barrett, Dr. Gruber and Dr. Keyport are the incumbents in that position. The floor is now open for nominations.

W. B. MITCHELL, M.D. (Kent): Mr. Speaker and Members of the House of Delegates: I would like to place in nomination the name of Dr. C. R. Keyport of Grayling to succeed himself as Delegate to the American Medical Association.

THE SPEAKER: The name of Dr. Keyport has been proposed.

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, it is a great pleasure to place in nomination the name of Dr. W. D. Barrett to succeed himself.

THE SPEAKER: Dr. Barrett has been nominated.

W. S. JONES, M.D. (Menominee): Mr. Speaker, I would like to place in nomination the Councilor from Thirteenth District, W. H. Huron. Dr. Huron has been at Iron Mountain twenty-two years. He has been president and the secretary of the society. He has served you well for ten years as a Councilor.

I think that if you go back in history, the Upper Peninsula has had one delegate to the American Medical Association in thirty years. At the present time we need men who can represent the State of Michigan in the American Medical Association, who are friendly, who are young enough to have a lot of fight and who get along, who are old enough to be mature. Dr. Huron recently, as Councilor, went down to Washington, and I have been told that he made a very, very favorable impression on our Congressmen and our two Senators.

Dr. Huron is a man who gets along with everybody, and I am sure that those who know him will believe he will make a very fine delegate to the American Medical Association.

THE SPEAKER: The name of W. H. Huron has been proposed. Are there other nominations?

DOUGLAS DONALD, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: I wish to put in nomination the name of Dr. T. K. Gruber from Wayne.

THE SPEAKER: The name of Dr. Gruber has been proposed. Are there other nominations to come from the floor of the House?

W. B. HARM, M.D. (Wayne): I move the nominations be closed.

THE SPEAKER: Is that motion seconded?

F. G. BUESSER, M.D. (Wayne): I support it.

THE SPEAKER: Dr. Buesser of Wayne supports the motion. The Chair will ask, in all fairness, are there any other nominations? If not, the Chair will put the motion. All in favor say "aye"; opposed, "no." The motion is passed and we will proceed to the balloting. According to the Constitution, we will vote from the slate, and those candidates which receive the three highest number of votes will be elected, and the order of seniority will be determined by the number of votes.

In case you cannot read that far, Dr. Keyport, Dr. Barrett, Dr. Huron and Dr. Gruber are the nominees from which to choose three. Put three names on your ballot.

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, the point has been raised, and I think it should be announced from the Chair. Four names will invalidate a ballot, but less than three will not. Is that correct?

THE SPEAKER: That is right. If you wish to vote for only one or two, you may. If you put four names on the ballot the ballot will be thrown out. We are voting for three. You may vote for any number up to three.

(The votes were cast.)

XIV—Remarks re National Physicians Committee by Counselor C. E. Umphrey, Detroit

THE SPEAKER: While the tellers are working, I am going to ask Dr. Umphrey to take the microphone for a few minutes. He asked for the privilege of the floor, and if there is no objection, I will turn the floor over to Dr. C. E. Umphrey, Councilor of Detroit.

C. E. UMPHREY, M.D. (Wayne): Thank you, Mr. Speaker. I did ask for the privilege of the floor, but many of our members have left.

A number of questions have been raised about the National Physicians' Committee. I had hoped at this time to make some remarks about it. However, I have a lot of material and that material will be at one of the booths downstairs in the reception booth, and you can review it there, and if you have any questions, I hope you will ask them.

This load of information to the doctors is getting just a little bit heavy, and I want all of you who are here to know the facts about the National Physicians' Committee.

With those few words, instead of giving you the story I wanted to give you tonight, if you want information you know where it can be found. If you have questions to ask, we shall try to answer them satisfactorily. If they cannot be answered satisfactorily, I can resign as—not your State Chairman as the official of this body, because there has been nothing official between the State Society and the National Physicians' Committee.

THE SPEAKER: Thank you, Dr. Umphrey.

Dr. Foster, our Secretary, has an announcement or two he would like to make.

Thank you for being so patient, gentlemen. This is important business and we won't be very long.

(Announcements by Secretary Foster.)

THE SPEAKER: I thought it would be very fine if we could have a word, although they have no status now, from our ex-Presidents. We would like to hear from Henry Cook, who was President of the Society back in 1937.

HENRY COOK, M.D.: All I have to say is this, that I am very happy to be here and listen to your deliberations. I sort of stayed away from the state meetings for the last two or three years since I was a delegate, because I might feel that I am one of the enlisted men, as it is a very great pleasure not to have to carry the load and the responsibilities of the state organization.

I will say that you have advanced very far since I was Chairman of The Council and also the President of the Society.

I would just like to state that during the time when I was Chairman of The Council Dr. Penberthy was President, and Bill Burns was employed. It might interest you to know of our conference with Mr. Burns when he was employed. I don't know whether Mr. Burns is here, but we went down to meet him in the Wayne County Medical Building. We said to Bill, "You have been selected to be the Executive Secretary of the Michigan State Medical Society. About what do you think you ought to get?"

Bill said,—I don't know the amount.

We said, "That is done."

Then Bill said, "What do you expect me to do?"

We said, "Well, if we didn't think you knew what you ought to do, we would not have employed you. So just go ahead and do your job."

Grover said, "What time does the ball game start?" and we went to the ball game.

I would like also to take credit myself, personally, for recommending Dr. Foster as the Chairman of the Public Relations Committee, the first Public Relations Committee which the Michigan State Medical Society had. Due to the good work that he did in the organization of the work of the Public Relations Committee, he advanced to the position he now holds.

That might be of interest to you. Those facts are all true. I am very happy, as I say, to be with you.

THE SPEAKER: Thank you, Dr. Cook.

It is a pleasure to see one other living and fairly well moving ex-President here, and here he is—Dr. Penberthy.

G. C. PENBERTHY, M.D.: Mr. Speaker, Gentlemen and Friends: I am sorry that I missed this evening's session, but I just brought Dr. Frank H. Lahey of Boston, one of our guest speakers, in from Willow Run, and I hope the proceedings were friendly and that all went well. I don't know what went on during the discussion of certain Reference Committee activities, but I will be interested to learn about them. I don't know who has been elected. It is very interesting.

As a member of the Wayne County Medical Society, I extend my greetings to the men from out in the state. We are happy always to have the State Society as our guest. Thank you.

THE SPEAKER: Thank you very much.

Dr. Breakey, will you step to the microphone and announce the results of the election?

R. S. BREAKEY, M.D. (Ingham): The three elected delegates to the American Medical Association are Drs. Barrett, Gruber and Huron.

THE SPEAKER: Drs. Barrett, Gruber and Huron. Is that sufficient? Are you satisfied the tellers have rendered their report?

R. S. BREAKEY, M.D. (Ingham): Sworn and testified to by all six tellers.

XIII—g. ALTERNATE DELEGATES TO AMA

THE SPEAKER: The next order of business is the election of Alternate Delegates to the American Medical Association. The present incumbents are Drs. Novy, Denham and Owen. We are to elect three men for these positions, for Alternate Delegates to the American Medical Association.

L. W. HULL, M.D. (Wayne): Mr. Speaker and Gentlemen: I would like to place in nomination the name of Dr. R. L. Novy for Alternate Delegate to the AMA.

E. D. SPALDING, M.D. (Wayne): I second the motion.

THE SPEAKER: R. L. Novy has been nominated. Are there other nominations?

W. B. MITCHELL, M.D. (Kent): I would like to place in nomination the name of R. H. Denham as an Alternate Delegate.

THE SPEAKER: R. H. Denham has been nominated. Are there any other nominations?

W. B. HARM, M.D. (Wayne): I would like to take the opportunity of placing in nomination the name of Dr. C. I. Owen of Detroit, Wayne County.

THE SPEAKER: C. I. Owen has been nominated.

Are there other nominations?

T. P. WICKLIFFE, M.D. (Houghton): I move the nominations be closed.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

THE SPEAKER: It has been moved and seconded that the nominations be closed. Is there any discussion?

R. S. BREAKEY, M.D. (Ingham): My recollection is that in the past—at least it is true in our County Society and I believe it is true in this House—in the choice of Alternate Delegates, in case the regularly elected Delegate cannot attend the Alternates serve in order of the most votes.

THE SPEAKER: Right.

R. S. BREAKEY, M.D. (Ingham): There is a first, second, and third choice of alternates.

THE SPEAKER: Right.

R. S. BREAKEY: There will have to be some sort of vote on this. I am not looking for work either.

THE SPEAKER: The motion before the House is that the nominations be closed. Is there any further discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

Gentlemen, there are three nominees for this position. Will the tellers please pass the ballots? The nominees are Dr. Novy, Dr. Owen and Dr. Denham. There are three vacancies and there are three nominees.

I will read from the new Constitution so we will all understand. Before you vote, gentlemen, will you listen?

"At each annual election, candidates for Delegates to The House of Delegates of The American Medical Association shall be nominated in number equal to or greater than the number to be elected that year. Election shall be by ballot. The required number of high candidates shall be declared elected.

"In case of a tie vote of high candidates, the winner, or winners, shall be decided by drawing lots; supervised by The Speaker of The House of Delegates; provided, however, that any candidate thus tied shall have the right to a decision by ballot if he requests same.

"The number of Alternate Delegates shall equal the number of Delegates. They shall be elected in exactly the same manner after all Delegates have been elected.

"Alternate Delegates shall have relative seniority according to the respective number of votes received by them, and such seniority shall be designated at the time of election."

In other words, gentlemen, you may vote for one, two or three. If everyone in the House votes for three, then the votes will be tied and seniority will be decided by drawing the names from the hat.

The three nominees are Dr. Novy, Dr. Denham and Dr. Owen.

R. S. BREAKEY, M.D. (Ingham): Since all three men will be elected alternate delegates, if the members of the House would vote for one or two we would establish priority by vote.

THE SPEAKER: I urge the members of the House to vote just as they wish.

R. S. BREAKEY, M.D. (Ingham): That was only a suggestion. Then you wouldn't have to draw by lot. That is all.

THE SPEAKER: Yes, the members of the House may vote for one, two or three. You have three nominees for three jobs: Dr. Novy, Dr. Denham and Dr. Owen.

(The votes were cast.)

THE SPEAKER: Gentlemen, I think it is rather interesting to hear from some of our ex-Presidents. I am going to call to the microphone now Dr. Claude R. Keyport of Grayling, who was President in 1943-1944, and who has been very active as Delegate to the American Medical Association and very active in Michigan State Medical Society affairs ever since. Dr. Keyport.

CLAUDE R. KEYPORT, M.D.: Mr. Speaker and Members of the House: I am very happy to be here again. For many years I have been active in Michigan State Medical Society, and I intend to continue my activities so far as possible.

During my term of office as President we were in the war and at that time our meetings were possibly not as many, and we were not showing the same amount of activity that we have since the war.

The House of Delegates and the members of the Michigan State Medical Society have been very kind to me, in the fact that I have been a member of this House for many years, your President-Elect, President, and at the same time a Delegate to the American Medical Association, which position I held for a number of years.

I am happy to release that tonight, and I don't know of anyone I would rather have take my place in the American Medical Association House of Delegates than my good friend, Dr. Huron. Thank you.

XIII—h. PRESIDENT-ELECT

THE SPEAKER: Gentlemen, the next order of business is the election of a President-Elect. Dr. Ledwidge's term will be concluded tomorrow. Dr. Sladek will become President tomorrow, and it is our duty to elect a President-Elect at this time. Are there any nominations for the position of President-Elect of the Michigan Sate Medical Society?

H. H. RIECKER, M.D. (Washtenaw): I wish to place in nomination the name of Dr. W. E. Barstow for President-Elect.

THE SPEAKER: The name of Dr. William E. Barstow, Councilor, has been placed in nomination.

M. G. BECKER, M.D. (Gratiot-Isabella-Clare): I wish to support the name of Dr. Barstow.

THE SPEAKER: Are there other nominations for the position?

L. C. HARVIE, M.D. (Saginaw): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Barstow.

THE SPEAKER: The motion is that the nominations be closed and the Secretary instructed to cast the ballot for Dr. Barstow, which would be a unanimous ballot.

W. B. HARM, M.D. (Wayne): I second the motion.

THE SPEAKER: The Chair feels it is incumbent on him to ask if there are other nominations, before taking the vote. You have heard the motion which has been seconded by Dr. Harm of Wayne. Is there any discussion? If not, all in favor signify by saying "aye"; opposed, "no." The motion is passed. I declare Dr. Barstow has been elected President-elect of the MSMS.

Will the Credentials Committee please escort the President-Elect to the rostrum.

Gentlemen, when there are more men on the platform than there are in the audience, we will adjourn the meeting.

(The delegates rose and applauded as Dr. Barstow was escorted to the platform.)

THE SPEAKER: Welcome to our growing circle, Dr. Barstow.

J. J. O'MEARA, M.D. (Jackson): Mr. Speaker, your President-Elect.

THE SPEAKER: Gentlemen, before we go into that grueling business, let us hear from our President-Elect, Dr. Barstow.

W. E. BARSTOW: Gentlemen, I have nothing in particular to say, except I certainly appreciate the honor that has been conferred upon me by the House. Thank you.

XIII—i. COUNCILOR—8th DISTRICT

THE SPEAKER: Nominations are now in order for the Councilorship of the Eighth District.

T. B. TREVNOR, M.D. (Mecosta-Osceola-Lake): I wish to nominate Dr. L. C. Harvie of Saginaw County for Councilor of the Eighth District.

THE SPEAKER: Dr. L. C. Harvie of Saginaw has been nominated. Are there any other nominations?

What is your pleasure, gentlemen?

H. H. RIECKER, M.D. (Washtenaw): If I were in that district I would want to have a little consultation with the other members, if any, of that district to decide whom we wanted for Councilor, and we could excuse them from the meeting to talk it over a little bit. If they have done that, I am very glad.

M. G. BECKER, M.D. (Grat. Isabella-Clare): We have done that.

H. H. RIECKER, M.D. (Washtenaw): We are glad it has been done.

THE SPEAKER: Thank you, Dr. Riecker. Dr. Riecker always sees a lot of things some of us miss.

L. L. SAVAGE, M.D. (Tuscola): I move the nominations be closed.

(The motion was seconded.)

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed and Dr. Harvie has been elected to the position of Councilor of the 8th District.

XIII—j. SPEAKER OF THE HOUSE OF DELEGATES

The next order of business is the election of the Speaker of the House. Nominations are now in order for the position of Speaker of the House.

H. H. RIECKER, M.D. (Washtenaw): Mr. Speaker and Members of the House: I wish to place in nomination, as Chairman of the Delegation of Washtenaw County, the name of J. S. DeTar, as Speaker of the House for the coming year.

(R. H. BAKER, M.D., the Vice Speaker, took the chair.)

R. A. SPRINGER, M.D. (St. Joseph): Mr. Speaker, may I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. DeTar.

T. Y. HO, M.D. (Clinton): I second the motion.

THE VICE SPEAKER: It is moved and seconded that the nominations be closed and the Secretary be instructed to cast the unanimous ballot. The present Speaker gives you a chance for other nominations, but I am afraid to request it. All in favor say "aye"; opposed. I declare Dr. DeTar, re-elected as Speaker of The House of Delegates.

(J. S. DeTar, M.D., the Speaker, resumed the chair.)

THE SPEAKER: I want to assure you that this is not as cut and dried as it appears to be.

I hesitated before to think that I should take another year at this job in case I were nominated. I feel that this position should be rotated fairly rapidly, certainly every two or three years. However, you have seen fit to give me this responsibility, and now I should like to give some of this responsibility back to you. This organization is only as good as every member of it. It is difficult at the beginning of the year, it is difficult in June, for a Speaker to choose Reference Committees properly. There undoubtedly are many members of the House of Delegates who would be willing and very glad to serve on Reference Committees. It is difficult to know, without meeting many of you in advance, who has the willingness to work, the desire to work and special interest in certain things.

I would, therefore, like to ask each member of the House of Delegates who is appointed next year—and many of you undoubtedly will be elected next year—I would like to ask you, and I am going to ask you by mail as soon as I can after your election, to write me what are your special interests, whether you would be interested in serving on a Reference Committee, and your suggestions for the more efficient running of the House of Delegates.

Nominations are now open for the position of Vice Speaker.

XIII—k. VICE SPEAKER OF HOUSE OF DELEGATES

T. H. PAULI, M.D. (Oakland): Mr. Speaker, I wish to nominate Robert Baker for the position of Vice Speaker.

THE SPEAKER: The name of Dr. Robert Baker of Oakland County has been placed in nomination. Are there other nominations for the position of Vice Speaker?

R. S. BREAKEY, M.D. (Ingham): Mr. Speaker, I would like to move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot of this House for Dr. Baker.

THE SPEAKER: Is that motion supported?

T. Y. HO, M.D. (Clinton): I second the motion.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

Dr. Baker, congratulations! Dr. Baker has been a very great help this year, and I am sure that he will be ready to take on additional duties next year.

Dr. Breakey, are you ready with your report?

XIII—g. REPORT ON ELECTION OF ALTERNATE DELEGATES TO AMA

R. S. BREAKEY, M.D. (Ingham): The order in which the Alternate Delegates were voted was as they are on the board—1, 2, 3.

THE SPEAKER: Dr. Novy received the largest number of votes, Dr. Denham, second, and Dr. Owen was third, and therefore they will appear in that order as Alternates to the House of Delegates of the American Medical Association.

I should like to call on an additional ex-President here. I think the next in line is Dr. Brunk. Dr. Brunk, what happened during your regime?

A. S. BRUNK, M.D.: Mr. Speaker, you asked me what happened in my regime. Well, many things happened, of course, as in all the years that the other men have served. I don't know of anything particularly outstanding that happened, not that I can put my finger on at this paricular time that you would be interested in.

I do want to say that I appreciated very much the honor of being invited to the platform and asked to say a few words. I do think, however, that my term of office is just a little bit too recent for me to again impose myself upon you and try to make a speech. I want to thank you for the courtesy.

THE SPEAKER: Thank you, Dr. Brunk.

Dr. Ray S. Morrish of Flint, whose term of office was 1944-1945. Dr. Morrish.

RAY S. MORRISH, M.D.: Mr. Speaker and Members of the House: I wish the Speaker had asked me the question, what happened when I was elected. If I remember rightly, I was pitched into the presidency at about 4 a.m., and through the death of our beloved Dr. Vernor Moore. It meant I didn't have a year's time as President-Elect to think up what some of the policies might be or who my committeemen might be and, if I remember correctly, I had about three weeks' time to work out my committee appointments. Certainly with the good help of The Council and other officers, and during the Annual Meeting with your help, we managed to whittle through some way.

It was a pleasure to serve a year as your President, and perhaps I didn't have the opportunity when I left office, but I will take it now. I certainly thank all for the very kind help and the loyal help which you gave me at that time.

THE SPEAKER: Thank you. Now we will close the meeting, but before we do, I want to say that I feel that the House of Delegates, as the governing body of the Michigan State Medical Society, has a debt of gratitude to certain people.

XV—Thanks of Speaker DeTar to MSMS Officers, House of Delegates, Reference Committee and Personnel

First, I should like to mention our Secretary, Dr. Foster. Dr. Foster has spent so far this year 110 days in the service of the Michigan State Medical Society. He has made twenty speeches away from home, all the way from West Virginia to South Dakota, in addition to carrying on a busy practice.

Dr. Ledwidge has been President of this Society not only in name but in fact. Dr. Otto Beck has spent many hours as Chairman of The Council. Dr. A. S. Brunk has been a very capable Treasurer, doing our business for us.

I would like to mention Mr. William J. Burns and Mr. Hugh W. Brenneman and their staffs. They have been working against almost insurmountable odds in very small, cramped offices in Lansing. We hope they will have a better office soon.

I would hate to close the meeting without special mention of Dr. T. K. Gruber, who did a terriffic amount of work on the Constitution, and I certainly think the names of our Reference Committee Chairmen—Dr. Lightbody, Dr. Bromme, Dr. Donald, Dr. Spalding, Dr. Stucky, Dr. Krieg, Dr. Weston, Dr. O'Meara, and Dr. Smith—should be mentioned. Some of those committees worked until 3 a.m. during the session. They and their committees certainly deserve our special thanks, and also Dr. Baker, who is the Vice Speaker.

I should like to thank the members of the press for their courtesy. We were glad to have you with us—and also Miss Hatton, our stenotypist.

Gentlemen, I should like all elected officers to be in the front row or the front two rows tomorrow night during the Officers' Night ceremony.

I should like to close this meeting with our very best wishes to our President-Elect, E. F. Sladek.

XVI—Adjournment

The meeting is adjourned.

(The Eighty-third Annual Session of the House of Delegates adjourned at eleven-twenty o'clock.)

ASSESSMENT TO PROVIDE EDUCATIONAL PROGRAM

At the recent St. Louis interim session of the American Medical Association, the House of Delegates unanimously voted to assess each member of the Association $25. The fund thus provided will be used for a nationwide plan of education on the progress of American medicine, the importance of the conservation of health and the advantages of the American system in securing a wide distribution of a high quality of medical care. The assessment will come to the members through the state and county societies.

POSTGRADUATE CONTINUATION COURSES
Wayne University College of Medicine
December 13, 1948-March 19, 1949

These courses are open to all qualified persons.

Veterans who are not Residents in a Detroit hospital and who have Certificates of Eligibility under the GI Bill, should make arrangements for tuition and books, as provided by the GI Bill, by presenting these Certificates of Eligibility to Mr. Arthur Johnson, Veteran's Administrator at Wayne University, Building N (rear), 465 W. Kirby.

If you do not possess a Certificate of Eligibility, please call Dr. Johnson at Temple 1-1450, Veterans Affairs, before going to his office, and he will inform you what papers it is necessary to bring with you. *This must be completed before you register.*

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, *before December 10.*

Title of Course	*Place*	*Time*	*Fee*
	Anatomy		
Surgical Anatomy *(Limited to 20 Senior Surgical Residents)*	College of Medicine	Tuesday 3–5	$35.00
Advanced Histology	College of Medicine	Monday 2–4	35.00
	Pathology		
Neuropathology	College of Medicine (Limited to 25)	Friday 1–5	50.00
Pathology of Neoplasms	College of Medicine (Limited to 35)	Wednesday 1–5	50.00
Advanced Hematology	College of Medicine (Limited to 5)	Monday 1–5	50.00
Dermatopathology	College of Medicine (Limited to 15)	Tuesday 1–5	50.00
	Radiology		
Beginning Physics in Radiology	St. Mary's Hospital	First meeting, Tuesday December 14, 4:00	15.00
	Physiological Chemistry		
Seminar	College of Medicine	Wednesday 4–5	15.00
Special Topics	College of Medicine	Thursday 4–5	15.00
	Physiology and Pharmacology		
Survey of Pharmacology	College of Medicine	Tuesday 4–5	15.00
Endocrinology	College of Medicine	Mon. & Th. 4–5	25.00
	Dermatology		
Seminar	Receiving Hospital	Wednesday 10–12	15.00
Conference on Venereal Diseases	Social Hygiene Clinic	Thursday 4–5:30	15.00
	Internal Medicine		
Diagnostic Conference	Receiving Hospital (Limited to 10)	Saturday 10–12	15.00
	Wayne County General	Wednesday 4–5	15.00
Gastroenterology	Receiving Hospital (Limited to 10)	Saturday 8–9	15.00
Medical X-Ray Conference	Receiving Hospital (Limited to 10)	Tuesday 11–12	15.00
	Wayne County General	Friday 1–2	15.00
Medical Pathological Conf.	Wayne County General	Thursday 11–12	15.00
Allergy Clinic & Conf.	Receiving Hospital (Limited to 8)	Tuesday 8–11	25.00
	Surgery		
Seminar	College of Medicine (Limited to 20)	Thursday 4–5	15.00

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

RESEARCH IN SYPHILIS

A new research study in the epidemiology of syphilis has been initiated in the state by the Bureau of Venereal Disease Control, Michigan Department of Health. The co-operation of every practicing physician is invited. The project is concerned primarily with techniques in syphilis case finding, particularly, patient interviewing and contact tracing.

Theoretically, there should be discovered an infected contact for each case of primary or secondary syphilis. Actually this has not been true in Michigan. It has not been unusual in the past to have a case of primary or secondary syphilis name four or five contacts within the usual incubation period. It has happened repeatedly that all of these contacts may be located and examined without a single one being found infected. The most probable sources of error are: (1) inadequate interviewing (including wilful naming of contact that is not actually a contact); (2) locating the wrong person by investigator in cases where there is not complete identifying information; (3) an incomplete medical examination which did not discover the contact's infection.

For the purposes of this study, one venereal investigator has been placed in each of three strategic locations in the state. Following contact interviews in the Michigan Rapid Treatment Center, contact information will be transferred immediately to the State Health Department office and then to an investigator, usually within twenty-four hours. The investigator will immediately attempt to locate the contact and get him to the family physician for an examination. If the contact is located, the results of this examination will usually be known in sufficient time so that if no infection is discovered the patient-informant may be reinterviewed while still at the Rapid Treatment Center.

When the contact has informed the investigator of the name of the physician to whom he will report for examination, the investigator will relay the available contact-information to the physician so that he may have this before taking the history and doing the physical examination. The physician will be asked to report the results of his examination of the contact as soon as possible so that if no infection is discovered further investigation can be made.

This project should result in a relatively large number of referrals to practicing physicians for the specific purpose of determining the presence or absence of syphilitic infections, and for treatment if treatment is indicated.

Much of the success or failure of this research in venereal disease epidemiology will depend upon the active participation and co-operation of practicing physicians in the state. It is believed that results of this study will help improve venereal disease epidemiologic activity and general venereal disease control in Michigan.

TRICHINOSIS SPREAD THROUGH CITY GARBAGE

The feeding of untreated city garbage to hogs increases the danger of trichinosis in hogs and in man.

The sanitary land-fill method of disposal is being recommended. This involves the burial of refuse beneath fill dirt to allow the refuse to settle and decompose. Each day's collection of garbage is sealed off completely on all sides by packed earth. This method cuts down on flies, rats, odors, smoke, open dumps and the health hazards. A tract of land, which can later be used for recreation area, and a caterpillar tractor with bull-chain attachment are the major requirements for such a system.

WHOOPING COUGH INCIDENCE DOWN

Whooping cough is at a new low in the state. Bureau of Disease Control records show that 2,379 cases of the disease have been reported so far this year in comparison with 8,713 at the same time last year. Seven Michigan children have died of whooping cough to date this year, in comparison with an average of 50 deaths at this time in previous years.

RABIES SPREADS NORTHWARD

Rabies in animals by November had spread north of the Muskegon-Bay City line, generally thought to be the northern limit of the 34-county danger area.

A case of rabies in a dog in Oscoda county is believed to have been contracted from a skunk. If a skunk was the source of infection, a reservoir of the disease may exist in wildlife in the area.

Two cases of rabies in dogs were reported from Antrim county.

POLIO LESS COMMON AFTER CHILD IS FIFTEEN

Analysis of the Michigan incidence of poliomyelitis by age groups for the six-year period, 1942 through 1947, indicates that approximately 75 per cent of the cases occurred with age groups under fifteen years and approximately 25 per cent in the age groups, fifteen and over. The only exception was in 1943 when only 65.5 per cent of the cases were in children under fifteen years.

FLUID TETANUS TOXOID AVAILABLE

Fluid tetanus toxoid is now available in 1 c.c. vials, 10 vials to a package.

MOST BREAKFASTS POOR

Nine poor breakfasts are eaten for every good breakfact eaten in the state according to Mrs. Alice Smith, Chief Nutritionist of the Department. Breakfast neglect, she says, is most common among children, particularly

(Continued on Page 1416)

(Continued from Page 1414)

teen-agers, among office, plant and factory workers, and among housewives, especially the mothers of little children. It reveals itself in irritability, fatigue, poor morale, lowered ability to concentrate, lowered efficiency, poor work performance, nervousness, accidents and—even wrinkles, Mrs. Smith contends.

SWEETS CAUSE MOST TOOTH DECAY

Eating sweets is the major cause of tooth decay among Michigan children, according to Dr. Fred Wertheimer, Director of the Bureau of Public Health Dentistry, who is urging Michigan parents to cut down on their children's use of gum (including the bubble variety), candy, pop, chocolate syrup drinks, cookies, cake, pie, jam, jelly and sugar.

He says that the early topical application of sodium fluoride to a child's teeth can reduce tooth decay by nearly half even when the use of sweets is not cut.

USE OF FILM LOAN LIBRARY DOUBLES

Use of the Department's Film Loan Library on health and educational subjects for lay and professional people has more than doubled during the past year. The library was started in 1940. It includes films, film strips, and slides on 159 different topics. They were shown to 355,426 Michigan people in 6,241 gatherings last year.

DELIVERY OF SPECIMENS TO DEPARTMENT

All samples and specimens which are delivered to the Michigan Department of Health for laboratory analysis should be left at the reception desk in the C. C. Young Laboratory building and not in the Administration building.

ADDITIONAL LABORATORY APPROVED

The laboratory of Children's Hospital, 5224 Antoine Street, Detroit, has met requirements permitting performance of enteric bacteriological examinations.

HEART FILM WIDELY SHOWN

The heart disease film "Be Your Age" was shown in one-third of the theaters in the state this spring and summer, according to the Metropolitan Life Insurance Company booking agent for the film.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	October 1948	October 1947
Diphtheria	19	10
Gonorrhea	793	967
Lobar pneumonia	40	60
Measles	313	774
Meningogoccic meningitis	10	10
Pertussis	98	641
Poliomyelitis	161	115
Scarlet fever	259	285
Syphilis	904	1247
Tuberculosis	597	473
Typhoid fever	10	5
Undulant fever	29	25
Smallpox	0	0

In Memoriam

ELDWIN R. WITWER, M.D., was born in Huron County, Ontario, Canada, August 23, 1890. He graduated from the Detroit College of Medicine in 1914 and took postgraduate training in Radiology at Cook County Hospital in Chicago. He held the title of Assistant Professor of Radiology at Wayne University and was well known for his organizational work in the Wayne County Medical Society and as a Councilor of the Michigan State Medical Society. Dr. Witwer was past president of the Detroit Roentgen Ray and Radium Society, and for twenty-two years served as its secretary and treasurer. In 1944 he was elevated to the presidency of the Radiological Society of North America. He was a fellow of the American College of Radiology and served the college as chancellor. He was chairman of the Committee on Radiology in Public Health and Industry of the American Medical Association and served on a similar committee in the American Roentgen Ray Society. His medical fraternity was Phi Rho Sigma. Dr. Witwer died on November 2, 1948 at his home in Detroit, Michigan, at the age of fifty-nine years.

CHARLES V. CRANE, M.D., Grand Rapids, Michigan, was born November 28, 1881 in Lake Odessa, Michigan, and graduated from the University of Michigan Medical School in 1904. During World War I, Doctor Crane served as a Lt. Colonel in the Army Medical Corps, and for seventeen years was a member of the Medical Corps. He was a Fellow of the American College of Physicians and Diplomate of the American Board of Internal Medicine in 1937, a member of the Kent County Medical Society, the American Medical Association and the Michigan State Medical Society. He was also a member of the American Diabetic Society, the American Heart Association and the National Gastroenterological Society. Dr. Crane passed on October 10, 1948, in Grand Rapids, Michigan, at the age of sixty-six years.

JAMES F. DARBY, M.D., St. Ignace, Michigan, was born on August 29, 1871 in Dresden, New York, and graduated from the Michigan College of Medicine and Surgery, Detroit, Michigan, in 1895. Dr. Darby was a former president of the Chippewa-Mackinac County Medical Society and a former member of the American Medical Association and the Michigan State Medical Society. He had practiced in St. Ignace, Michigan, for fifty years and had presided at the birth of more than 5,000 infants. Dr. Darby died on September 25, 1948 in St. Ignace, Michigan, at the age of seventy-seven years.

FRANK E. DAWSON, M.D., Detroit, Michigan, was born in Nashville, Tennessee, in 1878 and graduated from the Meharry Medical College, Nashville, Tennessee, in 1917. Dr. Dawson was well known in the negro community of Detroit, and was a member of the Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. He died in Detroit, Michigan, on October 12, 1948 at the age of seventy years.

JOSEPH HANSON, M.D., of Detroit, Michigan, was born April 3, 1876 in Chicago, Illinois. He graduated from the Dearborn Medical College, Chicago, in 1905, and was a member of the Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. Hanson died on September 16, 1948 at the home of his son, in Saginaw, Michigan, at the age of seventy-two years.

WILLIAM B. HOLDSHIP, M.D., of Ubly, Michigan, was born July 26, 1876 in N[illegible] London, Wisconsin, and graduated from the Saginaw Valley Medical College, Saginaw, Michigan, in 1902. Dr. Holdship was president of the Huron County Medical Society in 1926-27 and in 1934. He served seventeen years on the Village Council, was village president four years and president of the Board of Education the past two years. He was a member of the Huron County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. Holdship died on September 30, 1948 in Bad Axe, Michigan, at the age of seventy-two years.

CHARLES DAVID HUBER, M.D., Charlotte, Michigan, was born November 8, 1875, in Lodi, Ohio, and graduated from the Wayne University College of Medicine in 1901. Doctor Huber was a former President of the Eaton County Medical Society, a Life Member of the Michigan State Medical Society, and a member of the American Medical Association. He had practiced medicine in Charlotte, Michigan, for more than forty years and died at his home on September 1, 1948, at the age of seventy-two years.

HARLAN D. MacMULLEN, M.D., of Mainstee, Michigan, was born on February 14, 1880 in Osceola County, Michigan, and graduated from the University of Michigan Homeopathic Medical School in 1905. He served as a Captain in the Army Medical Corps during World War I. Dr. MacMullen was Councilor of the 9th District of the Michigan State Medical Society from 1933 to 1937, a Fellow of the American College of Surgeons, a retired member of the Manistee County Medical Society, the American Medical Association and the Michigan State Medical Society. He passed away October 6, 1948 in Manistee, Michigan, at the age of sixty-eight years.

RUSSELL HENRY RENZ, M.D., of Detroit, Michigan, was born in Detroit, Michigan on June 19, 1889. He graduated from the Wayne University College of Medicine in 1914 and was a former member of the

Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. Doctor Renz died in Detroit, Michigan, in September, 1947, at the age of fifty-eight years.

ARTHUR JAY ROBERTS, M.D., Jackson, Michigan, was born in Clinton, New York, on March 27, 1859, and graduated from the University of Michigan Medical School in 1885. Doctor Roberts was a former President of the Jackson County Medical Society, an Emeritus member of the Michigan State Medical Society, a member of the "Fifty Year Club," and a member of the American Medical Association. He had practiced at the same location in Jackson for more than fifty years. Doctor Roberts died in Detroit, Michigan, on August 27, 1948, at the age of eighty-nine years.

RAYMOND R. WHITTEN, M.D., of Ionia, Michigan, was born September 29, 1884, and graduated from the Wayne University College of Medicine in 1912. Doctor Whitten was a member of the Ionia-Montcalm County Medical Society, the American Medical Association and the Michigan State Medical Society. He passed away on September 11, 1948, in Blodgett Memorial Hospital, Grand Rapids, Michigan, at the age of sixty-four years.

THE OREGON CASE

(Continued from Page 1326)

members of defendant medical societies should refuse to consult in the diagnosis, care, or treatment of patients of doctors co-operating in medical care plans other than those sponsored or approved by the defendants; or of doctors who are not members of defendant medical societies;

(11) That defendant medical associations be perpetually enjoined from refusing to give approval to any medical care plan on the ground that said plan is controlled or sponsored by a commercial organization; or that said plan provides for medical care of patients having incomes above any given amount; or that said plan would compete with one or more other medical care plans approved or sponsored by the defendants;

(12) That defendant medical societies be required to advise in writing all of their component county medical societies, and to publish a statement in *Northwest Medicine,* that it no longer be the policy of said medical societies to do those things which, as hereinbefore alleged, They have combined and conspired to do, specifically including those things which defendants are enjoined from doing;

(13) That the plaintiff have such other and further relief as the court may deem just and proper;

(14) That the plaintiff recover its costs.

Communications

Michigan State Medical Society
2020 Olds Tower
Lansing 8, Michigan
Gentlemen:

This hospital has been authorized by the Surgeon General, Department of the Army, to employ civilian Medical Officers (General) on a full or part time basis. This authorization has been provided because of the present critical shortage of regular Army Medical Officers.

Because of this critical shortage I am canvassing all Medical Societies and Associations for assistance in obtaining qualified civilian Medical Officers.

Any publicity or assistance which your society may provide in aiding this hospital to obtain either *full* or *part* time civilian Medical Officers will be appreciated.

Thanking you in advance, I remain

Sincerely yours,

(signed) H. D. Offitt,
Brigadier General, USA
Commanding
Percy Jones General Hospital
Battle Creek, Michigan

November 10, 1948

Ann Arbor, Michigan
November 3, 1948

Dear Doctor Sladek:

I was deeply moved by your very gracious and inspiring statement on "Michigan's Pioneering Scientists" in the October issue of The Journal of the Michigan State Medical Society. Such statements as yours go far in stimulating best effort in medical research.

When Doctor Haughey asked me if I would submit some material dealing with the early development of the Kahn test, I did not imagine that The Journal would come out with so fine a commemorative issue. I have already expressed my thanks to Doctor Haughey and the Publication Committee of The Journal. But I feel that I should also like to thank you and, through you as President, the members of the Michigan State Medical Society for this commemorative issue. I have been highly honored by my own colleagues, and it will remain a great incentive to carry on to the best of my ability.

Yours cordially,

(Signed) Reuben L. Kahn

Ann Arbor, Michigan
November 3, 1948

Dear Doctor Haughey:

When your letter came last July requesting that I submit some material to The Journal of the Michigan State Medical Society, I did not imagine that this request would lead to so splendid a commemorative issue. My most sincere thanks to you and to the members of the Pub-

lication Committee of THE JOURNAL for conceiving and publishing this October issue. I also deeply appreciate the fine compliment paid me by the President of the Michigan State Medical Society, Dr. E. F. Sladek, on his President's Page. It is also a pleasure to express my appreciation of the helpful efforts of your highly efficient Executive Secretary, Mr. Wm. J. Burns, toward the production of this issue of THE JOURNAL.

It is no light matter for one to be so highly honored by his own colleagues not on the completion of his work but at a time when he is still filled with hopes to make significant contributions in his field. Such recognition can only serve as an incentive to strive to be worthy of this honor. I want to assure you that I shall do my very best to continue my studies in the interest of medical science, and that I shall always consider it a privilege to serve the members of the Michigan State Medical Society.

Yours cordially,

(Signed) REUBEN L. KAHN

Hempstead, New York
October 16, 1948

Dear Doctor Haughey:

I received today, a marked copy of THE JOURNAL of the Michigan State Medical Society for September, 1948.

The marked paragraph was in the middle of the second column of page 1034, headed "World Medical Association." There are three mistakes in this paragraph. It should read, "Any member of the Michigan State Medical Society may become a Founder Sustaining Member of the United States Committee of the World Medical Association."

Membership in the World Medical Association itself is limited to national medical associations.

In the fourth line my first name is misspelled.

In the fifth line there is given a combination of my New York and my Hempstead addresses. It should read, "2 East 103rd Street, New York 29, New York." The error in address is particularly important as there is no 103rd Street in Hempstead, and all communications relative to the World Medical Association should be sent to the office of that association in New York.

I would appreciate it if you could run a correction in your next issue.

Sincerely yours,

LOUIS H. BAUER, M.D.
Board of Trustees, AMA

RADIUM DISCOVERED FIFTY YEARS AGO THIS MONTH

Radium was discovered by Marie and Pierre Curie in Paris late in December, 1898.

"On this fiftieth anniversary of its discovery the value of radium for the treatment of cancer and other diseases is well established and its limitations are well known," Dr. Christie says in his editorial, adding:

"We pause to pay tribute to the discoverers and pioneers, but in proportion as we have their faith and vision we will fix our eyes upon the possibilities of progress which are opening up before us in the field of radioactivity. Much has been accomplished already in exploration of the field of the artificially produced radioactive isotopes."—American College of Radiology, December, 1946.

. . . . . NEWS MEDICAL

"Michigan is one state that is setting the pace in prepayment of health care."—GEN. PAUL R. HAWLEY, M.D.

* * *

R. L. Novy, M.D., Detroit, has been elected as a trustee of Michigan Hospital Service to fill the unexpired term of Wilfrid Haughey, M.D., resigned.

* * *

England's socialized medicine experiment reminds one of that old quotation, "The people love the early stages. A honeymoon is always pleasant."

* * *

L. Fernald Foster, M.D., spoke to the Kalamazoo Academy of Medicine on November 16 at its regular monthly meeting. His subject was "Good Public Relations Pay."

* * *

Of the 3,399 registrants at the 1948 MSMS Annual Session in Detroit, 1,598 came from Wayne County (1,371 were from Detroit, alone).

In addition, 186 came from outside Michigan, including 80 from Canada!

1949 Institute.—A good Doctor of Medicine is always under instruction. Plan to attend the 1949 Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit, March 23-24-25—a continuation course with forty-three good instructors.

David J. Sandweiss, M.D., Marcus H. Sugarman, M.D. and Bruce C. Lockwood, M.D., all of Detroit, are authors of an original article, "Enterogastrone and Duodenal Ulcer," which appeared in *JAMA* of October 23, 1948.

* * *

"Doctors' Wills and Estates" was the interesting subject of an address before the Ingham County Medical Society presented by Cyril Heilmann, a member of the legal profession of Michigan.

* * *

The Michigan State Board of Registration in Medicine stated, as of November 8, 1948, that it reinstated the medical licensure of William A. Kopprasch, M.D., and Carl W. Wagar, M.D.

R. S. Breakey, M.D., Lansing, delivered his presidential address on "Problems of Enuresis," to the North Central Section of the American Urological Association in Des Moines, Iowa, on October 28.

* * *

LeMoyne Snyder, M.D., J. D., and Wm. J. Burns, LL.B., Lansing, have been appointed members of the Medical Jurisprudence Committee of the State Bar of Michigan for the year 1948-49 by President Frank H. Boos of Detroit.

* * *

Grover C. Penberthy, M.D. and Clifford D. Benson, M.D., Detroit, are authors of an original article "The Complications of Meckel's Diverticulum in Infants and Children," which was published in *Surgical Clinics of North America,* October, 1948.

* * *

R. Wallace Teed, M.D. of Ann Arbor, Michigan, read a paper at the annual meeting of the Academy of Ophthalmology and Otolaryngology, October 10 to 15, in Chicago, on "Contribution of War Experience to the Etiology of Otitis Media."

* * *

Infant Mortality in Michigan.—In 1946 there were 4,552 deaths of infants under one year of age as against 4,035 in 1945, but due to the greatly increased number of births the rate decreased from 35.8 per thousand live births to 32.7, a decrease of 3.1 per thousand.

* * *

E. I. Carr, M.D., Lansing, was appointed by President E. F. Sladek, M.D., to represent the Michigan State Medical Society at a conference arranged by the American Cancer Society, Michigan region, to plan for extension of home nursing service. The meeting was held in Lansing on November 12.

* * *

Diabetes.—There is reported to be 2,500,000 known diabetics in the United States. The American Diabetic Association has announced a campaign to find the estimated 1,000,000 hidden cases. A shorter blood sugar test is being experimented with, and an improved insulin.

* * *

Detroit Dermatological Society.—At the annual meeting the following officers were elected by the Detroit Dermatological Society: Charles E. Reyner, M.D., Detroit, president; Frank Stiles, M.D., Lansing, president-elect; Herbert H. Holman, M.D., 2010 David Broderick Tower, Detroit, secretary-treasurer.

* * *

H. W. Brenneman, MSMS Public Relations Counsel, addressed a joint meeting of the Public Relations Committees of the Calhoun County Medical Society and of the Michigan State Pharmaceutical Association in Marshall on October 26. The meeting stressed closer contact between these two professional groups and better understanding of mutual problems.

* * *

Michigan Medical Service.—The annual meeting of the Directors of Michigan Medical Service, held in Detroit, October 13, resulted in the re-election of the same

officers: Robert L. Novy, M.D., president; Wilfrid Haughey, M.D., vice president; P. L. Ledwidge, M.D., secretary, and Frank McAllister, treasurer. Mr. Milton Grinnell resigned, and the vacancy was filled by the election of E. C. Baumgarten, M.D., of Detroit.

* * *

The Michigan Society of Anesthesiologists held its monthly meeting, December 1, in Lansing.

The program was a symposium on Intravenous Procaine. Dr. W. G. Mackersie discussed the "Use of Intravenous Procaine in Thoracic Surgery"; Dr. Ivan B. Taylor, "The Use of Intravenous Procaine in General Surgery"; and Dr. N. M. Bittrich, "The Therapeutic Uses of Intravenous Procaine."

* * *

L. Fernald Foster, M.D., Bay City, addressed the Michigan Society for Crippled Children and Adults at its twenty-fifth annual meeting in Flint on October 29. His subject was "Our Michigan Rheumatic Fever Diagnostic Center Program—New Developments."

Carleton Dean, M.D., Lansing, presented the Michigan Crippled Children Commission's "amputee and brace reconditioning and retraining program" on October 30, at the MSCC Annual Session.

* * *

Veterans Administration will soon receive formal notification by the American Legion of actions taken at its recent Miami convention which pertained to medical and hospitalization activities . . . among them were rejection of proposals to add chiropractors to VA staffs, opposition to any "federal socialized medicine program," endorsement of provision of living quarters for hospital staff doctors.—Washington Report on the Medical Sciences, November 1, 1948.

* * *

C. E. Umphrey, M.D., Detroit, represented the Michigan State Medical Society in a one-day institute entitled "Community Resources for Adult Medical Care in Michigan" sponsored by the Michigan Welfare League and held in Detroit, December 6, as part of the MWL Annual Conference. The panel and round-table discussions included representatives of the medical, hospital, and health professions and directors of welfare and vocational rehabilitation.

* * *

Vocational Rehabilitation. The State Office of Vocational Rehabilitation requests that, in forwarding statements for medical care of its clients, the examining physician fill in his usual charge for the service rendered, according to the Uniform Fee Schedule for Governmental Agencies. However, where this is not done, no amount will be entered by the Vocational Rehabilitation office without prior consultation with the physician concerned.

Vocational rehabilitation has set a fee of $8 on rehabilitation examinations. This is an improvement over the fee for similar examinations paid by insurance companies.

For a copy of the Vocational Rehabilitation examination blank, write N. Bernita Block, M.D., Medical Consultant, State Board of Control for Vocational Education, Bauch Bldg., Lansing 4, Michigan.

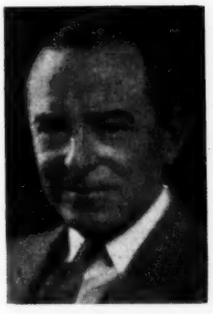
* * *

Robert M. Eaton, M.D., Grand Rapids, was top winner in the contest for medical papers published in recognized state and national medical journals prior to January 1, 1948—awarded by the Foster Foundation Committee on Medical Prizes. Dr. Eaton's "Pulmonary Edema" won him a $250 prize.

William H. Deemboer, M.D., and Henry P. Kooistra, M.D., took second place ($100), Aymer M. Hill, M.D., and Jerome E. Webber, M.D., placed third, ($100) and John T. Hodgen, M.D., and Charles H. Frantz, M.D., fourth ($50).

* * *

Workingmen's Worries.—The November number of *Fortune Magazine* contains an article giving the results of a questionnaire of the UAW-CIO showing the things which cause the working men worry. The average age of the CIO worker is 42.7 years and the average number of dependents is 3.1, which is one whole dependent less than the average for the state. 28 per cent of them worry about what they would do to care for their families in case of illness and 15 per cent of them worry about how they would take care of the medical and health expenses of their dependents. This is a very interesting survey and worth reading.



Frederick A. Coller, M.D., Ann Arbor, was chosen as president-elect of the American College of Surgeons in Los Angeles at its 1948 meeting the week of October 18.

Congratulations, Dr. Coller, and full success in your new position.

* * *

M.H.S.: Five of the thirteen Sisters of Mercy hospitals in Michigan which withdrew from participation in the Blue Cross program in 1946 have again become Blue Cross hospitals, it was announced on November 10 by William S. McNary, executive vice president of Michigan Hospital Service, the Blue Cross Plan.

The hospitals are: Mercy Hospital, Muskegon; Mercy Hospital, Cadillac; Leila Y. Post Montgomery Hospital, Battle Creek; Mercy Hospital, Jackson; and St. Lawrence Hospital, Lansing.

* * *

According to John Perkins, state controller, the state has three ways to balance the budget since Proposal No. 2 was defeated and sales tax diversion continues: (1) Levy a state income tax, a state property tax or various "nuisance" taxes; (2) Recapture such present grants in aid to local governments as the intangibles tax, racing

revenues, etc.; and (3) Make local units responsible for such present state services as welfare, care of tuberculous patients, old age assistance and aid to dependent children.—*Michigan Survey, November,* 1948.

* * *

90th Division Forming Association.—All former members of the 90th Infantry Division are invited to affiliate with the Michigan Chapter of the National Association now being formed.

The association is being formed to perpetuate the friendships formed while serving our country in time of war in the United States, England, France, Belgium, Luxembourg and Germany.

Communications should be addressed to Frank A. Schmidt, Jr., 65 E. Fairmont Avenue, Pontiac, Michigan.

* * *

The Governor of Michigan, Mr. Kim Sigler, called a conference at the Olds Hotel, Lansing, November 11, 12, and 13, on "Children and Youth in Michigan." The purpose was to study the present staff of public and private services to the children, evaluation in the light of today's need, and plan for the future so that Michigan may offer the greatest public encouragement, inspiration, and help to its future citizens. There were five general sessions, group luncheons, and twenty-two section conferences, also a Governor's Dinner on Friday evening, November 12.

* * *

Michigan Deaths, 1947.—The Federal Security Agency reports deaths in Michigan for 1946, 54,899; for 1947, 56,847. A total of 1,445,370 deaths were registered in the United States during 1947. This represents an increase of 49,753 deaths over the number recorded for 1946. "The crude death rate for 1947 was 10.1 deaths per thousand estimated population. *This is the second lowest rate ever recorded for the United States. The lowest was 10.0 in 1946."* This from the FSA report, and THIS WAS UNDER A SYSTEM OF VOLUNTARY PRIVATE MEDICAL PRACTICE!

* * *

Dr. Reuben L. Kahn, Ann Arbor, was honor guest at a testimonial dinner at the Statler Hotel, Boston, arranged by the Conference of State and Provincial Public Health Laboratory Directors, on the occasion of the Annual Dinner of the Conference, November 7.

A formal presentation was made to Dr. Kahn of the first copy of the October, 1948, JOURNAL, MICHIGAN STATE MEDICAL SOCIETY, to come off the press, which commemorated the 25th Anniversary of the Kahn reaction. G. Don Cummings, M.D., Lansing, Director of Laboratories of the State of Michigan, made the presentation address.

* * *

The Family Doctor in magazine articles.—

1. The *Saturday Evening Post* of October 9 contained an article on a Texas general practitioner.

2. *Life* Magazine on September 20 carried an interesting story concerning a Colorado general practitioner, as well as an editorial entitled "General Practice vs. Specialization."

3. *Woman's Home Companion* recently purchased full-page advertisements in metropolitan newspapers to

carry its message entitled "Give Young Doctors a Break" to the public. Although the story was badly garbled, it did point the finger at some impractices in certain hospital setups in certain parts of the U. S.

* * *

The Michigan State Pharmaceutical Association invites the attention of the medical profession to a portion of the agreement which it has with the Veterans Administration for pharmaceutical service to VA patients: No doctor of medicine may prescribe medicine for a veteran under the VA program unless he is specifically authorized in each instance (for each patient, per month) to make out such prescription. These prescriptions are checked carefully by the Pharmaceutical Association and any doctor who writes prescriptions on patients for whom he has no authorization from VA will be billed for the prescription.

* * *

President-elect W. E. Barstow, M.D., of St. Louis, comments that he has many times noticed the danger of driving at night when long freight trains are moving. He has cared for many patients who were injured by driving into moving freight trains which they could not see. He suggests that the Interstate Commerce Commission, which is probably the only authority that can control this condition, require that every freight car carry three reflectors on each side which will flash back the lights of the driver's automobile when approaching a moving freight train at night, thus giving notice that there is something ahead. As the trains are now equipped, the long line of freight cars gives no warning in the dark, and on the country roads there are no lights at the crossings.

* * *

The convention dollar means a great deal to the host city. For example, Cleveland recently surveyed the conventionneer's dollar and found the following disbursement:

Hotel accommodations (including rooms, food, and incidentals)—37.18 cents
Restaurants—15.7 cents
Beverages—9.85 cents
Retail stores—12.99 cents
Local transportation—4.18 cents
Theaters—1.44 cents
Sight seeing—0.29 cents
Amusements—8.62 cents
Gas, oil, car service—1.87 cents
Miscellaneous—7.88 cents

* * *

New Intramural Postgraduate Course in Cancer. This important course begins Tuesday, January 25, and continues daily through Friday, January 28, 1949; it will deal primarily with the four most common cancers, namely, those of the skin, breast, uterus, and rectum. The course will be offered to qualified practitioners residing in Michigan. The program will be given in the University Hospital, Ann Arbor, Michigan, and will consist of four general lectures, one on each day of the course, and also four daily sessions on pathology. The entire group of physicians will attend those periods. The re-

mainder of the day will be given over to clinical sessions, the group being divided into four sections. Each section will rotate through four clinical sessions on successive days. For applications, your members may write to H. H. Cummings, M. D., Chairman, 1313 E. Ann St., Ann Arbor, Michigan.

* * *

Study of Michigan Basic Science Act and of Michigan Medical Practice Act.—A joint committee representative of the Michigan State Medical Society, the Michigan Board of Examiners in Basic Sciences, and the Michigan State Board of Registration in Medicine, has been appointed to study possible changes in the Michigan Basic Science Act of 1937 and in the Michigan Medical Practice Act of 1899.

The personnel of this committee, appointed by the president of the Michigan State Medical Society, is as follows: P. L. Ledwidge, M.D., Detroit, Chairman, and E. F. Sladek, M.D., Traverse City, representing the Michigan State Medical Society; O. E. Madison, Ph.D., Detroit, and Donald A. Kerr, D.D.S., Ann Arbor, representing the Board of Examiners in Basic Sciences; and C. B. Gardner, M.D., Lansing, and L. J. Gariepy, M.D., Detroit, representing the Michigan State Board of Registration in Medicine. This joint committee was appointed as the result of a meeting of representatives of the three groups held in Lansing on October 11.

* * *

Almost three out of every four of the twenty-four and twenty-five-year-olds called up for pre-induction physical examinations are unfit for military service, according to a survey of the nation's ten largest cities.

Selective service officials reported that the rejection rate varies from 87.5 per cent in New York City to 37 per cent in Los Angeles. The average is 72 per cent, as compared with 35.8 per cent during World War II.

Heart ailments and psychoneurotic disorders are the principal causes of rejection.

Selective service officials said that because veterans are exempted from the new draft, most of those being examined now were 4-Fs during the war or held essential jobs. Selective Service Director Lewis B. Hershey said the rejection rate among the twenty-four and twenty-five-year-olds is just about what he expected, perhaps a shade better.

* * *

If the rate of 72 per cent continues, the Army will not be able to fill its three-month quota of 45,000 men from the ranks of the twenty-four and twenty-five-year-olds, as it had planned. It has asked for 10,000 this month, 15,000 in December, and 20,000 in January.—B. C. Enquirer News, Nov. 3, 1948.

* * *

Longer Life for Doctors.—Early in 1940 the class of 1900 of the College of Physicians and Surgeons, Columbia University, New York, held its annual dinner. As the toll of members who had died in the last year was intoned, the surviving doctors blinked with shocked surprise. A group of the naughty-naughts, then in their late 60s, began to investigate the alarmingly high death rate. The next year a Committee on Longevity was announced, with Dr. Charles E. North, bacteriologist, as chairman.

The committee's findings were equally shocking. A gallstone authority did not know he had gallstones. A hernia specialist had a hernia. Other members had poor sight and nose and throat ailments. Only three had normal weight; 35 were too fat and 23 too thin.

On advice of the committee, all members of the class agreed to take frequent examinations and treatments for any ailments discovered. Classmates examined each other without charge. Last week the committee made an official report on the eight-year plan. In that time the group, averaging 75 years, had an annual death rate of five members. This compares favorably with a national rate of 6.7 persons in 100 over 65, as listed in a government survey.—Extract from *Newsweek,* October 25, 1948.

* * *

Bill Porter — Olympic Hurdles Record Breaker. —Horace Wray Porter, M.D., of Jackson, longtime and efficient Secretary of the Jackson County Medical Society, has good reason to be proud of his son Bill Porter, Northwestern University's great hurdler. To quote the *Northwestern Wildcat News:*

"Young Bill Porter climaxed his brilliant track career when he won the Olympic 110 meter hurdles championship at London in the record-breaking time of 13.9 seconds."

Dr. Porter's lanky son (6 feet 6 inches), in addition to his triumph at London, has also equalled the American indoor record for the 60 and 70 yard high as well as for the 70 yard low hurdles.

Congratulations, Dr. Porter, on your son's remarkable accomplishments!

* * *

The AMA Secretary's Letter of October 25, 1948, presented the following story about "Lucky Junior": Michigan Society produces new movie. Several persons from AMA headquarters recently saw a preview showing of "Lucky Junior," a new 10-minute movie produced under sponsorship of the Michigan State Medical Society. It is now being booked for showing by more than 400 theaters in Michigan. An estimated audience of more than 1,000,000 persons will see this motion picture, which is interesting and very well done. Subsequently, the state society plans to develop 16 mm. prints for showing to community groups.

"Lucky Junior" was chosen as the title for the educational film because it is designed to show the safeguards available to the child of today as compared with those of yesteryear.

The picture deals with the thoughts of a doctor who has just delivered his 2,000th baby. He recalls how he delivered the child's father twenty-five years ago, and

thinks how much better a chance this baby has to grow up to healthy manhood than his father had.

As the doctor recounts to himself the advantages which today's child enjoys, the picture illustrates modern protective measures—the up-to-date hospital, protection by immunization against such deadly diseases as whooping cough, diphtheria, and tetanus, and services such as the disease control programs.

EXTRACTS FROM 1948 MSMS HOUSE OF DELEGATES PROCEEDINGS

(Continued from Page 1316)

any segment of medicine cannot suddenly be changed by any single formula or law.

"WHEREAS, According to the principles of medical ethics it is unprofessional to accept rebates on prescriptions, appliances or perequisites from attendants who aid in the care of patients, we believe it will be the consensus of the House of Delegates that the membership of the Michigan State Medical Society and of the medical profession in general is as honest and as much to be trusted in all of its responsibilities as any other group of citizens, be it therefore

"RESOLVED, That it is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"That we urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

4. *Effort to increase the number of students graduated from medical schools.* The 1948 House of Delegates adopted the following resolution:

"RESOLVED that the Michigan State Medical Society, through its officers, support any reasonable means to increase the number of students graduated from medical schools in this state, and that the Delegates to the AMA take similar action at the next meeting of the American Medical Association House of Delegates."

An MSMS committee has been appointed to meet with the Deans of the two Medical Schools in Michigan, with the Governor, and with the Ways and Means Committee of the House and the Finance and Appropriations Committee of the Senate, State Legislature, to investigate the possibility of increasing the number of students graduated from medical schools in this State. The committee is composed of President E. F. Sladek, M.D., Traverse City, Chairman; Speaker J. S. DeTar, M.D., Milan, and Secretary L. Fernald Foster, M.D., Bay City.

Index to Volume 47

ARMY MEDICINE

AUTHOR'S INDEX

CONTRIBUTED PAPERS

A

BON SECOURS HOSPITAL CLINIC DAY

COMMUNICATIONS

DETROIT PHYSIOLOGICAL SOCIETY

THE DOCTOR'S LIBRARY

EDITORIAL COMMENT

EDITORIALS

IN MEMORIAM

MICHIGAN'S DEPARTMENT OF HEALTH

MICHIGAN MEDICAL SERVICE

MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

MICHIGAN STATE MEDICAL SOCIETY

MILITARY MEDICINE

MISCELLANEOUS

POLITICAL MEDICINE

PRESIDENT'S PAGE

PUBLIC RELATIONS

WOMAN'S AUXILIARY

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1. Lennox, W. C. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. **2.** Merritt, H. H. (1947), Recent Advances in the Treatment of Epilepsy, with Particular Emphasis on the Use of Tridione, Arch. Neurol. & Psychiat., 57:130, Jan. **3.** Gibbs, F. A. (1947), New Drugs of Value in the Treatment of Epilepsy, Annals Int. Med., 27:548, Oct. **4.** Fetterman, J. L., and Weil, A. A. (1947), Practical Aspects of Epilepsy (with special consideration of epilepsy in children), Med. Clin. N. America, 31:1273, Sept. **5.** Liebert, E. (1947), Treatment of Neurological Disorders with Tridione, Ill. Med. J., 91:311, June.

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